

4780

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Virginia		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda Rural		LENGTH OF STAY (in this place) 1 mo 6 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dumfries 83X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 83 Tripoli Heights			
3. NAME OF DECEASED: (First) (Middle) (Last) Ralph Douglas ADAMS				4. DATE (Month) (Day) (Year) OF DEATH: May 19 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 3-17-55	9. AGE last birthday yrs. 2	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days 2	Hours 2 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Ray F. ADAMS				14. MOTHER'S MAIDEN NAME: Margaret A. TANQUESLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No. None		17. INFORMANT & ADDRESS: Father Capt Ray F. ADAMS USMC Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Congestive failure						1 month	
ANTECEDENT CAUSE (S) (B) Congenital Heart Disease (Transposition of great vessels, IV septal defect, patent ductus + coarctation of aorta)						2 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 13 Apr, 1955 , to 19 May, 1955 , that I last saw the deceased alive on 19 May 1955 , and that death occurred at 4:10 AM , from the causes and on the date stated above. DATE SIGNED D. J. PASCOE D. J. PASCOE LT MC USN U. S. Naval Hospital, NNM, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 23 May 1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 19 May 1955		REGISTRAR'S SIGNATURE Mary E. Casselby		24. FUNERAL DIRECTOR Chambers Funeral Home		ADDRESS 3072 M Street, N.W. Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V.S.

MAY 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4750 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 21 Film G182 5-27-55 ans

CERTIFICATE OF DEATH

Reg. Dist. No. 04751 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
17 TOWN <u>Takoma Park</u>		11 days		TOWN <u>Takoma Park</u>		17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
75 <u>Washington Sanitarium & Hosp.</u>				8027 <u>Glenside Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Barbara Jane Amerman</u>				<u>May 14 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F	W	married	June 10, 1911	43 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Personnel Natl. Labor Relations Board</u>		<u>Kansas</u>		<u>USA.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William F. Lindley</u>				<u>Alice Heller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
no						<u>Washington Sanitarium & Hospital Records.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
928.0 IMMEDIATE CAUSE						<u>1/2 hour.</u>	
(A) <u>Pulmonary embolus</u>							
DUE TO							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>General thrombophlebitis, right 11 days</u>							
DUE TO <u>Femoral</u>							
(C) <u>Trauma to right leg, minor about 21 days</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
		Home		Takoma Park		15 (County) Montg. Md	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
Apr. 23 1955 M.		at work		Her dog struck leg, bruising it.			
22. I hereby certify that I attended the deceased from <u>JULY, 1954</u> , to <u>14 MAY, 1955</u> , that I last saw the deceased alive on <u>13 MAY, 1955</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Seneca T. Kemble</u>				<u>929 Pershing Dr. S.E. Md. 4 May '55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 18, 1955		Arlington Hall Cemetery		Arlington, Va.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		25. ADDRESS	
May 14-1955		<u>William Rodd</u>		<u>John R. Hall</u>		<u>254 CARROLL ST. N.W. TAKOMA PARK 12, D.C.</u>	

CONSTITUTION ACT OF 1947

THE CONSTITUTION ACT OF 1947, which provides for the establishment of a new government for the State of Hawaii, is hereby enacted into law.

SECTION 1. The State of Hawaii shall be a free and independent nation, and shall have the right to determine its own destiny.

SECTION 2. The State of Hawaii shall be a democracy, and shall be governed by the people.

SECTION 3. The State of Hawaii shall have a unicameral legislature, and shall have a governor and a cabinet.

SECTION 4. The State of Hawaii shall have a judicial branch, and shall have a supreme court.

SECTION 5. The State of Hawaii shall have a public service, and shall have a public defender.

SECTION 6. The State of Hawaii shall have a public health service, and shall have a public safety service.

SECTION 7. The State of Hawaii shall have a public education service, and shall have a public housing service.

SECTION 8. The State of Hawaii shall have a public transportation service, and shall have a public utility service.

SECTION 9. The State of Hawaii shall have a public water supply service, and shall have a public waste disposal service.

SECTION 10. The State of Hawaii shall have a public fire service, and shall have a public police service.

SECTION 11. The State of Hawaii shall have a public airport service, and shall have a public harbor service.

SECTION 12. The State of Hawaii shall have a public park service, and shall have a public recreation service.

SECTION 13. The State of Hawaii shall have a public library service, and shall have a public museum service.

SECTION 14. The State of Hawaii shall have a public art service, and shall have a public historical service.

SECTION 15. The State of Hawaii shall have a public music service, and shall have a public dance service.

SECTION 16. The State of Hawaii shall have a public theater service, and shall have a public opera service.

SECTION 17. The State of Hawaii shall have a public circus service, and shall have a public rodeo service.

SECTION 18. The State of Hawaii shall have a public fair service, and shall have a public festival service.

SECTION 19. The State of Hawaii shall have a public carnival service, and shall have a public parade service.

SECTION 20. The State of Hawaii shall have a public circus service, and shall have a public rodeo service.

SECTION 21. The State of Hawaii shall have a public fair service, and shall have a public festival service.

SECTION 22. The State of Hawaii shall have a public carnival service, and shall have a public parade service.

SECTION 23. The State of Hawaii shall have a public circus service, and shall have a public rodeo service.

SECTION 24. The State of Hawaii shall have a public fair service, and shall have a public festival service.

SECTION 25. The State of Hawaii shall have a public carnival service, and shall have a public parade service.

SECTION 26. The State of Hawaii shall have a public circus service, and shall have a public rodeo service.

SECTION 27. The State of Hawaii shall have a public fair service, and shall have a public festival service.

SECTION 28. The State of Hawaii shall have a public carnival service, and shall have a public parade service.

SECTION 29. The State of Hawaii shall have a public circus service, and shall have a public rodeo service.

SECTION 30. The State of Hawaii shall have a public fair service, and shall have a public festival service.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4781

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04752

Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Silver Spring</u>		<u>20 A.</u>		TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2023 Luzerne Avenue</u>				STREET ADDRESS (If rural, give location) <u>2021 Luzerne Avenue</u>			
3. NAME OF DECEASED:		(First) <u>William</u>		(Middle) <u>Russell</u>		(Last) <u>Antrim</u>	
(Type or Print)						4. DATE OF DEATH (Month) (Day) (Year) <u>May 30 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>5/20/93</u>	9. AGE last birthday: <u>62</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Printer - Hand</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Govt. Printing Office</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>William Antrim</u>				14. MOTHER'S MAIDEN NAME: <u>Carolyn Rummell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		(If Yes, give war or dates of service) <u>WW #1</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Laura B. Antrim, 2021 Luzerne Ave. Silver Spring, Md.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Coronary occlusion</u> DUE TO				<u>Sudden death</u>			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>6/2/55</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschant</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-30-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>6/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>6/2/55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Wanner & Pumphrey</u>		ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	

4782

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Virginia		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Falls Church 83X-3			
X TOWN Bethesda Rural		2 days		STREET ADDRESS (If rural give location) 2128 Arlington Boulevard ✓			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Thomas Preston APPLEBY				May 21 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
Male	White	Single	19 May 1955		2		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None			10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Dan P. APPLEBY				14. MOTHER'S MAIDEN NAME: Joan SIMARD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No			16. SOCIAL SECURITY NO. - -		17. INFORMANT & ADDRESS: Father LCDR Dan P. APPLEBY USN Same as above		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)			Atelectasis, Congenital				2 days
ANTECEDENT CAUSE (S)			Prematurity				2 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) DUE TO				
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 19 May, 1955 , to 21 May, 1955 , that I last saw the deceased alive on 21 May 1955 and that death occurred at 8:15AM , from the causes and on the date stated above.							
SIGNATURE M. S. Allen			ADDRESS M. S. ALLEN LT MC USN U. S. Naval Hospital, NMHC, Bethesda, Maryland				DATE SIGNED
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF 24 May 1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia
DATE REC'D BY LOCAL REGISTRAR 23 May 1955			REGISTRAR'S SIGNATURE Mary E. Parrelly		24. FUNERAL DIRECTOR ADDRESS R. A. Pumphrey Funeral Home 7557 Wisconsin Ave. Bethesda, Maryland		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-2-2
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BUREAU V. S.

MAY 26 1955

RECEIVED

4783

04754

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 218.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Montg</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Weatherbury</i>		LENGTH OF STAY (in this place) <i>15 yrs</i>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Weatherbury (rural)</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mt. Pleasant Ave</i>				STREET ADDRESS (If rural, give location) <i>Mt Pleasant Ave</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <i>Charles</i>		(Middle) <i>Berni</i>		(Last) <i>Arnold</i>		(Month) <i>May</i> (Day) <i>28</i> (Year) <i>1955</i> OF DEATH	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:		IF UNDER 1 YEAR Months Days Hours Min.	
<i>Male</i>	<i>White</i>	<i>Widowed</i>	<i>10-29-1867</i>	<i>87</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>R. Berni Arnold</i>				<i>unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<i>9</i>				<i>H.A. English - Same as Stein 2</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <i>Coronary occlusion</i> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Frank J. Brochant</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <i>5-28-55</i>			
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>May 31 1955</i>		<i>Darklane</i>		<i>Brookville Pike</i>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>May 31, 1955</i>		<i>Alvada Cook</i>		<i>Ray W. Barker</i>		<i>112</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04755
4784 CERTIFICATE OF DEATH Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Georgia		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 5 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Macon 49X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 143 Rogers Avenue ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) Bonnie Sue AWREY				4. DATE (Month) (Day) (Year) OF DEATH: May 28 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 10-10-04	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife			10B. KIND OF BUSINESS OR INDUSTRY: Housewife		11. BIRTHPLACE (State or foreign country): Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Franklin C. DAVIS				14. MOTHER'S MAIDEN NAME: Susan CLEVELAND			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Hugh R. Awrey 2633 15th Street, N.W. Washington, D. C.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cirrhosis of the Liver						1 year	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-24- , 1955, to 5-28-55 , 1955, that I last saw the deceased alive on 28 May , 1955, and that death occurred at 1135am , from the causes and on the date stated above. SIGNATURE G. I. Plitman ADDRESS U.S. Naval Hospital, NMHC, Bethesda, Maryland DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal Burial		DATE THEREOF 1 June 1955		NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		LOCATION (City, town, or county) (State) Macon, Georgia	
DATE REC'D BY LOCAL REGISTRAR 28 June 1955		REGISTRAR'S SIGNATURE Mary E. Parrelly		24. FUNERAL DIRECTOR A. A. Humphrey Funeral Home		ADDRESS 7557 Wisconsin Avenue, Bethesda, Md.	

BUREAU V. S.

JUN 3 1965

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4785

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04756
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Brookville</u>		RURAL <input checked="" type="checkbox"/> LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Brookville</u>		RURAL <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD - Box 129</u>				STREET ADDRESS (If rural, give location) <u>RFD</u>			
3. NAME OF DECEASED: (First) <u>Edwin</u> (Middle) <u>Ballinger</u> (Last) <u>Ballinger</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct 8 1891</u>	
9. AGE last birthday: <u>63</u> yrs.		10. AGE last birthday: <u>83</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Charles Ballinger</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>4 no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>✓</u>		17. INFORMANT & ADDRESS: <u>Mabel A. Ballinger (wife) Brookville MD</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO						<u>Sudden death</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-22-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Interred</u>		DATE THEREOF <u>May 27-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Excevell Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montg - New Jersey</u>	
DATE REC'D BY LOCAL REG. <u>May 27-55</u>		REGISTRAR'S SIGNATURE <u>Gertrude B. Fowler</u>		24. FUNERAL DIRECTOR <u>Arthur J. Talbot</u>		ADDRESS <u>254 Excevell St. Catonsville MD</u>	

RECEIVED

MAY 27 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04757

4786

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>--</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>17 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Roanoke</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>1916 Canterbury Road</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <u>Roy</u>		(Middle) <u>Franklin</u>		(Last) <u>Barnes</u>		<u>May 22 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>February 12, 1910</u>	9. AGE last birthday: <u>45</u> yrs.	IF UNDER 1 YEAR: <u>3</u> Months <u>10</u> Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Sales mgr.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Private industry</u>		11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Ben Barnes</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Smitherman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>234-07-1624</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory failure</u>							
ANTECEDENT CAUSE (B) <u>Primary tumor of left lung</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2--</u>		19B. MAJOR FINDINGS OF OPERATION: <u>--</u>		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) INJURY OCCUR? <u>--</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>--</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>May 5, 1955</u> , to <u>May 22, 1955</u> , that I last saw the deceased alive on <u>May 22, 1955</u> , and that death occurred at <u>8:25p M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>5/23/55</u>		M. D. <u>Natl. Institutes of Health</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>5-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Forestlawn</u>		LOCATION (City, town, or county) (State) <u>Logan Co., W. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

RECEIVED

MAY 26 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4787 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1804758

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 1, Film G181, 5/11/55

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6412 Western Ave.</u>				STREET ADDRESS (If rural give location) <u>6412 Western Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Katie</u> <u>Bauer</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 5, 1955</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct. 18, 1869</u>	9. AGE last birthday <u>85</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Nicholas Steinmacher</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Anna Horner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Paul Edgar Bauer - Son</u> <u>7502 Vale Street, Chevy Chase, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>48h</u>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Hypertensive Cardio Vascular</u>							
(C) <u>Renal Disease</u>						<u>10y</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-17</u> , 19 <u>40</u> , to <u>5-5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-5</u> , 19 <u>55</u> , and that death occurred at <u>1:36 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. Flit Rickett</u>		ADDRESS <u>5000 Rm Rd 17a</u>		DATE SIGNED <u>5-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/6/55</u>		REGISTRAR'S SIGNATURE <u>Beard M. Thompson</u>		24. FUNERAL DIRECTOR <u>The S. W. Hines Co.</u>		ADDRESS <u>2901 14th St., N.W.</u>	

RECEIVED MAY 9 1955

BUREAU V. S.

MAY 9 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4751
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 213

04759

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u> COUNTY <u>Montg</u>			
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
TOWN <u>Takoma Park</u>		<u>2 1/2 yrs</u>		TOWN <u>Takoma Park</u> <u>17</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 Pine Ave</u>				STREET ADDRESS (If rural, give location) <u>17 Pine Ave</u> <u>1</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Lewis</u>		(Middle) <u>Linwood</u>		(Last) <u>Beasley</u>		(Month) <u>May</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11-29-178</u>	9. AGE last birthday: <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Int. Revenue</u>		11. BIRTHPLACE (State or foreign country): <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Woodford T. Beasley</u>				14. MOTHER'S MAIDEN NAME: <u>Beel Dery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u>9</u>		17. INFORMANT & ADDRESS: <u>Crestwood Nursing home records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				<u>sudden death</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-21-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Br. Geo.</u>		LOCATION (City, town, or county) (State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>May 21, 1955</u>		REGISTRAR'S SIGNATURE <u>J. Helm Dodd</u>		24. FUNERAL DIRECTOR <u>A. H. Jones Co.</u>		ADDRESS <u>4100 E. 2901 14th St NW</u>	

RECEIVED

MAY 24 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 4: Film 6181-5-20-55L

4776

03762
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>507 Woodston Rd.</u>				STREET ADDRESS (If rural, give location) <u>507 Woodston Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>JEFFERSON C. BEEKER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 2, 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH: <u>3-25-15</u>	9. AGE last birthday: <u>40</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country): <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Thomas J. Beeker</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Leonard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> ✓		16. SOCIAL SECURITY No.: <u>WW 11</u>		17. INFORMANT & ADDRESS: <u>Cleo L. Beeker- Item # 2</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO						<u>Sudden death</u>	
Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-3-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
DATE REC'D BY LOCAL REG. <u>5/4/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Beator</u>		24. FUNERAL DIRECTOR <u>Robert H. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

MAY 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4788

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04760

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY in this place		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Bethesda</u>		<u>2 hours</u>		TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>74 Suburban</u>				<u>2570 Kimberly St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Bett Walter Edward Belt</u>				<u>May 12 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 12, 1900</u>	<u>54</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Foreman</u>		<u>Telephone Co</u>		<u>District of Columbia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Robert E. Belt</u>				<u>KATHERINE ALOXMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>NO</u>				<u>J. William Belt. 3059 Oliver NW WASHINGTON</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage - Rente</u>							<u>2 days</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerosis; generalized</u>							<u>yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral Fibrillation</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Angina Pectoris</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>0 mm</u>		<u>—</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/25/55</u> , 19..., to <u>4/12/55</u> , 19..., that I last saw the deceased alive on <u>4/12/55</u> , 19..., and that death occurred at <u>10:02 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel Allen</u>		ADDRESS <u>M. D. Kinsinger, M.D.</u>		DATE SIGNED <u>5/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/16/55</u>		<u>Washington National Cemetery</u>		<u>Prince Geo. County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/17/55</u>		<u>Bessie M. Thompson</u>		<u>Warner E. Humphrey</u>		<u>8434 Ga. Ave. Silver Spring, Md.</u>	

RECEIVED

MAY 19 1955

BUREAU V. S.

4752

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Laurens Park</i>		STATE <i>Pa</i> COUNTY <i>Mon</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Albany 83X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>807 Philadelphia Ave</i>				STREET ADDRESS (If rural give location) <i>609 Kenting Towers</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Evelyn V. Benton</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>May 23 1955</i>			
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <i>Dec 22, 1917</i>	9. AGE last birthday: <i>77</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Public Stenographer Emp.</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Self</i>		11. BIRTHPLACE (State or foreign country): <i>Arkansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>usa</i>	
13. FATHER'S NAME: <i>Wm. H. Benton</i>				14. MOTHER'S MAIDEN NAME: <i>Mary F. Worthington</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>9</i>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service):		17. INFORMANT & ADDRESS: <i>Miss Margie Nicholson 609 Centerville Rd. Albany, Va</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE						3-4 yrs	
(A) <i>Cardiac Decompensation</i>							
ANTECEDENT CAUSE (S)							
(B) <i>Atherosclerosis</i>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C) <i>Bronchopneumonia</i>						6-7 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Senility</i>						?	
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1955</i> , to <i>23 May, 1955</i> , that I last saw the deceased alive on <i>22 May, 1955</i> , and that death occurred at <i>7:24 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>William D. Culp</i>				DATE SIGNED <i>5/23/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>4-23-55</i>		NAME OF CEMETERY OR CREMATORY <i>Demaine St. Home</i>		LOCATION (City, town, or county) (State) <i>Albany Va</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 23, 1955</i>		REGISTRAR'S SIGNATURE <i>Frances Patten</i>		24. FUNERAL DIRECTOR <i>H. G. Rowe</i>		ADDRESS	

Emily Virginia Benton
Burial

May 24, 1955

Mt. Comfort Cemetery
Fairfax City, Va

Funeral Director

Wm Demain & Sons
Alexandria Va

BUREAU V. S.

MAY 26 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04762
4789 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Chevy Chase</u>		LENGTH OF STAY (in this place) <u>38 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u># 109 Quincy Street</u>				STREET ADDRESS (If rural give location) <u># 109 Quincy Street</u>			
3. NAME OF DECEASED: (First) <u>MARGARET</u> (Middle) <u>ALICIA</u> (Last) <u>BINGHAM</u>				4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>7-4-1878</u>	
9. AGE last birthday: <u>76</u> yrs.		Months <u>9</u> Days <u>28</u>		10. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Wash. DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>John McDonald</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Keohane</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>g</u>	
16. SOCIAL SECURITY No.: <u>9</u>		17. INFORMANT & ADDRESS: <u>Julia A McDonald, 5607 Brookville, Rd</u>		18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X</u> Immediate cause (a) <u>Cerebral Hemorrhage</u> Antecedent causes (s) (b) <u>Arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>				Interval Between Onset And Death <u>6 wks</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION: <u>✓</u>				19b. MAJOR FINDINGS OF OPERATION: <u>✓</u>			
21. ACCIDENT (Specify) <u>—</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u>		CITY OR TOWN <u>Chevy Chase, Maryland</u>		(COUNTY) <u>Montgomery</u> (STATE) <u>Md.</u>	
HOMICIDE		INJURY		HOW DID INJURY OCCUR?			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input checked="" type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Feb 15, 1955</u> to <u>May 2, 1955</u> , that I last saw the deceased alive on <u>May 2, 1955</u> , and that death occurred at <u>5:10 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>E. J. Kelly</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>3800 Oak Arb. W</u>		DATE SIGNED <u>5/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5-5-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>		LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/4/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons</u>		ADDRESS <u>1756 Pa. Ave. N.W. Washington, D. C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 6 1955

BUREAU V. S.

Johnson

John is back

John is back

John is back

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4790
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

04763

No. 218

I. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Clarksburg Rural LENGTH OF STAY (in this place) 4 yrs
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Montgomery COUNTY Montgomery
 CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Clarksburg
 STREET ADDRESS (If rural, give location) Rural 1708

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

IndiaBishop

4. DATE OF DEATH

(Month)

(Day)

(Year)

511955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FemaleWhiteWidowedFeb 16 - 187580 yrs.2 Months 15 Days19 Hours 55 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

few minutes

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at Not while work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Frank J. Broschart

CHIEF MEDICAL EXAMINER

DATE SIGNED

M. D. DEPUTY MEDICAL EXAMINER

5-1-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial5-4-55St JosephMaganzaMD

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 2, 1955Arndt J. ClarkeFrank B. Gartner, Faith'sbury

BUREAU V. S.

MAY 5 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04764

4791

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Bethesda</u>		<u>36 days</u>		<u>Bladensburg</u> <u>16-33-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location)			
<u>50 National Institutes of Health</u>				<u>4111 54th St.</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Theresa</u>		<u>P.</u>		<u>Blaine</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>F</u>		<u>W</u>		<u>Married</u>		<u>24 Apr. 1908</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>47</u> yrs.		Months		Days		Hours	
						Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>housewife</u>				<u>--</u>		<u>New York</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Henry S. Preston</u>				<u>Josephine Larson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>--</u> (If Yes, give war or dates of service) <u>--</u>				<u>--</u>		<u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinoma of breast with metastases to liver</u>							
ANTECEDENT CAUSE (S) DUE TO <u>lungs, brain, bones & multiple lymph nodes</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>None</u> <u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>None</u>		<u>None</u>					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 4, 1955</u> , to <u>May 10, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>8:35AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James A. Pittman</u>				DATE SIGNED <u>May 10, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 14, 55</u>		<u>Gen. Wash. Mem. Park</u>		<u>Prince Geo County MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/12/55</u>		<u>Beattie M. Thompson</u>		<u>W.W. Chamber</u>		<u>Co. 1400 Chapin St.</u>	

BUREAU V. S.

MAY 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04765
4792 CERTIFICATE OF DEATH Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Alexandria</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>21 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Alexandria</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>3124 Martha Custis Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Victoria Theresa Bogusky</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 18 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>18 April 1915</u>	9. AGE last birthday <u>40</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Secretary</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Alexander Mishinski</u>				14. MOTHER'S MAIDEN NAME: <u>Stella Kuznicki</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Rupture of pulmonary artery with massive hemorrhage at operation for ligation of patent ductus arteriosus.</u>							
ANTECEDENT CAUSE (S) (B) <u>Patent ductus arteriosus with reversal of flow.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Dilatation of atherosclerotic pulmonary artery.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>May 18, 1955</u>			19B. MAJOR FINDINGS OF OPERATION: <u>Patent ductus arteriosus with reversal of flow and dilatation of atherosclerotic pulmonary artery.</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21B. PLACE (Home, farm, factory, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Apr 27, 1955</u> , to <u>May 18, 1955</u> that I last saw the deceased alive on <u>May 18, 1955</u> , and that death occurred at <u>3:20P M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Seaman Tulin M.D. for Dr. Marrow</u>				DATE SIGNED <u>May 18, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>				DATE THEREOF <u>5/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cirlington, Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Fitzgerald Funeral Home Dr. Old</u>	
						ADDRESS <u>3245 Wilson Rd Cirlington Va</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1955

BUREAU V. S.

4793

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural-Potomac</u>				OR TOWN <u>Rural-Potomac</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u>				<u>Rt. #3 Box 126 Bethesda, Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>ALICE EMMA BONIFANT</u>				OF DEATH: <u>May 19,</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>12-25-63</u>	<u>91</u> yrs.	Months <u>4</u>	Days <u>24</u>	Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Montg. Co., Maryland</u>		<u>US</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James Bonifant</u>				<u>Laura Craigen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Florence Bonifant-Item # 2</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral anoxia -</u>						<u>1 day</u>	
ANTECEDENT CAUSE (S) DUE TO <u>Cerebral infarction -</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Antiplegic hypertrophic arthritis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/6</u> , 19 <u>54</u> to <u>5/19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/18</u> , 19 <u>55</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		DATE SIGNED <u>5/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-21-55</u>		<u>Potomac Cemetery</u>		<u>Potomac, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/23/55</u>		<u>Bessie M. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 26 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04767

4794

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockville - rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rockville - rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Boswell Lane - rural - RD#2		STREET ADDRESS (If rural, give location) Boswell Lane - R. F. D. #2	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
James	M.	BOSWELL, Sr.	
4. DATE OF DEATH	(Month)	(Day)	(Year)
May	28	1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 3/15/1882
9. AGE last birthday 73 yrs.		10. BIRTHPLACE (State or foreign country) Maryland	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Boswell		14. MOTHER'S MAIDEN NAME Mary catherine Melbrook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Martha C. Boswell- Same Item #2			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Carcinoma of Liver			2 years
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 1954 , to 28 May 1955 , that I last saw the deceased alive on 27 May 1955 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.			
SIGNATURE W. S. Humphrey, M.D.		ADDRESS Rockville, Md. DATE SIGNED 28 May 55	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/30/1955	Darnestown Presby	Montgomery Co. Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
5/31/55	Samuel St. Hughes	Robert A. Humphrey	Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 1 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04768

2411 N. Charles Street, Baltimore

4795

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RFD Laurel Maryland</u>	
TOWN <u>Burtonsville</u>		TOWN <u>Burtonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Doran Street</u>		STREET ADDRESS <u>Doran Street</u>	
3. NAME OF DECEASED (Type or Print) <u>SIMON</u> (First) <u>FRANKLIN</u> (Middle) <u>BOWERSETT</u> (Last)		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Mar 23, 1890</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Byrd Bowersett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elsie Ramey</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-12-1786</u>	
17. INFORMANT AND ADDRESS <u>son - Charles Bowersett - same address</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

446X
Immediate cause(a) uremic syndrome

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) kidney failure1 year(c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u></u>	(COUNTY) <u></u>	(STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>		

22. I hereby certify that I attended the deceased from 1 Jan, 1955, to 9 May, 1955, that I last saw the deceasedalive on 9 May, 1955, and that death occurred at 10 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/12/55</u>	NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Mem. Cemetery</u>	LOCATION (City, town, or county) <u>Prince Geo. County, Md.</u>	(State) <u></u>
DATE REC'D BY LOCAL REG. <u>May 13/55</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Warner C. Humphrey</u>	ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 17 1935

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04769
4753 CERTIFICATE OF DEATH Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> <u>47x-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. Hosp.</u>				STREET ADDRESS (If rural give location) <u>1206 Hemlock St. N.W.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Franklin Brandt</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>5-5-1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>7-31-92</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>11cen Hut Sales & Serr.</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Simon Brandt</u>				14. MOTHER'S MAIDEN NAME: <u>Ella Conkle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hosp. Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u> (A) <u>Rupture of Heart and Home pericardium</u>						<u>5/5/55</u>	
ANTECEDENT CAUSE (S): (B) <u>Myocardial Infarction</u>						<u>5/1/55</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Occlusion</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Congestive Heart Failure</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/24</u> , 19 <u>55</u> , to <u>5/5/55</u> , that I last saw the deceased alive on <u>5/5/55</u> , and that death occurred at <u>7:15 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. J. Snow</u>		M. D. <u>Takoma Park</u>		ADDRESS <u>5/5/55</u>		DATE SIGNED <u>5/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transit - 1st</u>		DATE THEREOF <u>5-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Canton</u>		LOCATION (City, town, or county) (State) <u>Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 6-1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Snow</u>		24. FUNERAL DIRECTOR <u>Wm. S. H. Hume</u>		ADDRESS <u>2801-14th Wash. D.C.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 9 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04770

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

1. PLACE OF DEATH - COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>D.C.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12,304 Dewey Road</u>		STREET ADDRESS (If rural, give location) <u>2727 N St., S.E.</u>	
3. NAME OF DECEASED (First) <u>Theodore</u> (Middle) (Last) <u>Broderick, Sr.</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 29, 1867</u>
9. AGE last birthday <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher - retired</u>	
11. BIRTHPLACE (State or foreign country) <u>New Orleans, La.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pat (Daniel) Broderick</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Engel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-30-3114</u>	
17. INFORMANT AND ADDRESS <u>Mr. Theodore Broderick, Jr.</u>		18. MEDICAL CERTIFICATION <u>12,304 Dewey Rd., Silver Spring, Md.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Immediate cause</u> <u>Coronary occlusion</u>		<u>sudden death</u>	
(b) <u>Antecedent cause(s)</u> <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broderick</u>		DATE SIGNED <u>5-28-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Trans. & Burial</u>		DATE THEREOF <u>05/28/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>New Orleans, La.</u>	
DATE REC'D BY LOCAL REG. <u>3-31-55</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u> ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 3 1955

BUREAU V. S.

4797

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04771

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Olney</u>		<u>11 hrs</u>		<u>Rockville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>				STREET ADDRESS (If rural give location)			
<u>713</u>				<u>Route 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Michael Eugene Butt</u>				<u>May 8 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>5/8/55</u>				<u>10 49</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Newborn</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Sidney Eugene Butt</u>				<u>Janice Lorraine Connolly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>9</u> (If Yes, give war or dates of service)				<u>Mother</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>762.5</u> <u>atelectasis (hyaline membrane?)</u>		<u>11 hrs.</u>
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Prematurity (7 1/2 months - 5 lb 2 oz)</u>		<u>-</u>
(C) <u>none</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>0</u>	<u>-</u>	

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 8, 1955 to May 8, 1955; that I last saw the deceased alive on May 8, 1955, and that death occurred at 10:30 PM from the causes and on the date stated above.

SIGNATURE <u>Dr. J. L. Luthin</u>	ADDRESS <u>Rockville, Md.</u>	DATE SIGNED <u>5/9/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>5-10-55</u>	<u>Darnestown Presbyterian Church</u>
LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR	ADDRESS
<u>Darnestown, Md.</u>	<u>Robert A. Humphrey</u>	<u>Bethesda, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	
<u>5-9-55</u>	<u>Arthur B. Lawler</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Attorney (Johnston) 11-11-55
Summerville 11-11-55

BUREAU V. S.

MAY 11 1955

RECEIVED

Summerville 11-11-55

Johnston 11-11-55

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4798

CERTIFICATE OF DEATH

Reg. Dist. No.

04772

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4530 Avondale St., Apt. # 8</u>				STREET ADDRESS (If rural give location) <u>4530 Avondale St., Apt. # 3</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)					
DECEASED: <u>MARY ANN FRANCES CARLIN</u>		OF DEATH: <u>May 11</u>				<u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Feb. 20, 1870</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>James Cordock</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Denin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mr Jos. M. Cohan- Item # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1 MYOCARDIAL INFARCTION</u>						<u>24 HOURS</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>CORONARY THROMBOSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIOSCLEROSIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>02</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1942</u> to <u>MAY 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>MAY 11</u> , 19 <u>55</u> , and that death occurred at <u>27</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Stewart S. Harvath</u>		ADDRESS <u>1501 84th St. N.Y. WASH. 63C.</u>		DATE SIGNED <u>5-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial-Transit</u>		<u>5-13-55</u>		<u>St. Raymonds-New York</u>		<u>New York, Bronx N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/12/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

RECEIVED

MAY 16 1955

BUREAU V. S.

4799

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>		LENGTH OF STAY (in this place) <i>3 months</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1507 East West Highway</i>				STREET ADDRESS (If rural give location) <i>1507 East West Highway</i>			
3. NAME OF DECEASED: (Type or Print) <i>Robert Miller Carnahan</i>				4. DATE OF DEATH: (Month) <i>May</i> (Day) <i>1</i> (Year) <i>1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>6 Sept 1880</i>	9. AGE last birthday: <i>74</i> yrs.	10. UNOER 1 YEAR		IF UNOER 24 HRS.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <i>Master Mechanic U.S. Naval Gun Factory</i>				11. BIRTHPLACE (State or foreign country): <i>Scotland</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>	
13. FATHER'S NAME: <i>Alexander Carnahan</i>				14. MOTHER'S MAIDEN NAME: <i>Grace McWhir</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <i>none</i>		17. INFORMANT & ADDRESS: <i>Margaret Goshink Carnahan (wife) 1507 E. W. Hwy</i>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>420.2 Immediate cause (a) <i>Asphyxia</i></p> <p>Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <i>acute cardiac dilatation</i></p> <p>(c) <i>cardiovascular renal disease with hypertension, decompensation, angina</i></p>							
Interval Between Onset And Death: <i>48 hrs</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>one year</i>							
19a. DATE OF OPERATION: <i>none</i>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1926</i> to <i>1 May</i> , 1955, that I last saw the deceased alive on <i>1 May</i> , 1955, and that death occurred at <i>9:40</i> , from the causes and on the date stated above.							
SIGNATURE <i>James Drattlingly, M.D.</i>				DATE SIGNED <i>1 May 55</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>				DATE THEREOF <i>5/4/55</i>		NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Crematory</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5-4-55</i>				REGISTRAR'S SIGNATURE <i>Frances Potter Warner & Humphrey</i>		24. FUNERAL DIRECTOR <i>8434 Georgia Ave. Silver Spring, Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 6 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4890 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04774											
Item 11: film G182 6-2-55 CERTIFICATE OF DEATH											
Reg. Dist. No. 216											
1. PLACE OF DEATH:					2. USUAL RESIDENCE (HOME) OF DECEASED:						
COUNTY <u>Montgomery</u> MARYLAND					STATE <u>Maryland</u> COUNTY <u>Montgomery</u>						
CITY (If outside corporate limits, write RURAL and give nearest town)					CITY (If outside corporate limits, write RURAL and give nearest town)						
X TOWN <u>rural - Kensington</u> LENGTH OF STAY (in this place) <u>4 months</u>					OR TOWN <u>rural - 4317 Saul Road</u> X						
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3000 McComus Ave.,</u>					STREET ADDRESS (If rural give location) <u>Kensington</u>						
3. NAME OF DECEASED: (First) (Middle) (Last)					4. DATE (Month) (Day) (Year)						
(Type or Print) <u>Frederic Webster Case</u>					OF DEATH: <u>May 21 1955</u>						
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>married</u>		8. DATE OF BIRTH: <u>October 11, 1904</u>		9. AGE last birthday <u>50</u> yrs. <u>7</u> Months <u>10</u> Days <u></u> Hours <u></u> Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Builder</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Real Estate</u>			11. BIRTHPLACE (State or foreign country): <u>California</u> <u>Denver, Col.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME: <u>Lewis Frederic Case</u>					14. MOTHER'S MAIDEN NAME: <u>Lena Winkler</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT & ADDRESS: <u>Mrs. Frederic Case, 4317 Saul Road Kensington, Md.</u>	
18. MEDICAL CERTIFICATION											
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Probable Pulmonary embolus</u>								immediate			
ANTECEDENT CAUSE (B) <u>Arteriosclerosis; hypertension</u>								18 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Glomerulonephritis</u>								18 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19A. DATE OF OPERATION: <u>0</u>			19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?					
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Jan. 2, 1954, to May 21, 1955, that I last saw the deceased alive on May 19, 1955, and that death occurred at 8:10 P.M. from the causes and on the date stated above.											
SIGNATURE <u>Katharine A. Chapman</u>					ADDRESS <u>Kensington, Md.</u> DATE SIGNED <u>May 21, 1955</u>						
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			DATE THEREOF <u>5-24-55</u>			NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			LOCATION (City, town, or county) (State) <u>Rockville Montg. Maryland</u>		
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>			REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			24. FUNERAL DIRECTOR <u>Robert R. Humphrey</u>			ADDRESS <u>Bethesda, Md.</u>		

BUREAU V. S.

MAY 26 1955

RECEIVED

MARYLAND

04775
STATE DEPARTMENT OF HEALTH

4754

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>TAKOMA PARK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>251 MANOR CIRCLE</u>		STREET ADDRESS (If rural, give location) <u>251 MANOR CIRCLE</u>	
3. NAME OF DECEASED (Type or Print) <u>BERTHA</u>	(First) <u>SHANKS</u>	(Middle) <u>CHANEY</u>	(Last)
4. DATE OF DEATH <u>MAY 21</u>	(Month)	(Day)	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG. 15, 1874</u>
9. AGE last birthday <u>80</u> yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>
11. BIRTHPLACE (State or foreign country) <u>CHATFIELD MINN.</u>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>JAMES ALEXANDER SHANKS</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE JOHNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>MRS JEANETTE WERMICH, 251 MANOR CIRCLE, TAKOMA PARK, MD.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) <u>Myocardial Infarction</u>		<u>4 weeks</u>
Antecedent cause(s) (b) <u>Atherosclerosis, Coronary & Generalized</u>		<u>10 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 April, 1955, to 21 May, 1955; that I last saw the deceased alive on 21 May, 1955, and that death occurred at 5:15 P. m., from the causes and on the date stated above.

SIGNATURE L. B. Snow M.D. (Degree or title) ADDRESS Silver Spring, Md. DATE SIGNED 21 May 1955

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>MAY 24, 1955</u>	<u>Hillside Cemetery</u>	<u>Manassas, Va.</u>	<u>Manassas, Va.</u>
DATE REC'D BY LOCAL REG.	REGISTERED SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>MAY 21, 1955</u>	<u>J. Arthur Walters</u>	<u>J. Arthur Walters</u>	<u>254 Carroll St. N.W. Takoma Park, D.C.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 24 1955

BUREAU V. S.

4891

CERTIFICATE OF DEATH

Reg. Dist. No. 516

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pittston</u> <u>75X-3</u>			
X TOWN <u>Bethesda</u>		<u>42 days</u>		STREET ADDRESS (If rural give location) <u>132 Elizabeth St.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>							
3. NAME OF DECEASED: (Type or Print) <u>Edward</u>		(First)		(Middle) <u>J.</u>		(Last) <u>Connors</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 27 1955</u>	
8. DATE OF BIRTH: <u>September 8, 1875</u>		9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Manager (Retired)</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Bowling Alley</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Luke Connors</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Curley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>160X Carcinoma of maxillary antrum with metastases to lung, liver, abdominal and thoracic lymph nodes</u>		
ANTECEDENT CAUSE (B) <u></u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>	
--	--

19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION <u>--</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>	

22. I hereby certify that I attended the deceased from Apr. 15, 1955 to May 27, 1955, that I last saw the deceased alive on May 27, 1955, and that death occurred at 12:55 M. from the causes and on the date stated above.

SIGNATURE <u>Saroad Altman, M.D.</u>		ADDRESS <u>The Clinical Center Natl. Institutes of Health</u>		DATE SIGNED <u>5/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>5-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	
				LOCATION (City, town, or county) (State) <u>Pittston, Pa.</u>	

DATE REC'D BY LOCAL REGISTRAR <u>5/28/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert G. Humphrey</u>	
				ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 31 1955

RECEIVED

4802

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>W. Virginia</u> COUNTY <u>Wyoming</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
<u>X</u> TOWN <u>Bethesda</u>		<u>115</u> days		TOWN <u>Pineville</u> <u>85X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50</u> <u>The Clinical Center</u> <u>National Institutes of Health</u>							
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Booster</u>		<u>Charles</u> <u>Cook</u>		DEATH: <u>May</u> <u>28</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 29, 1907</u>	<u>47</u> yrs.	Months <u>9</u> Days <u>31</u> Hours <u></u> Min. <u></u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Miner</u>				<u>United Mine Workers</u>		<u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Cook</u>				<u>Joclie Workman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>not available</u>			
17. INFORMANT & ADDRESS:				<u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pylephlebitis with suppurative hepatitis</u>							
ANTECEDENT CAUSE (S) (B) <u>Subdiaphragmatic abscess</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>May 16, 1955</u>		<u>Subdiaphragmatic abscess, intestinal obstruction</u>					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County)		(State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 2, 1955</u> , to <u>May 28, 1955</u> , that I last saw the deceased alive on <u>May 28, 1955</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>The Clinical Center</u> <u>M. D. National Institutes of Health</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial-transit</u>		<u>5/28/55</u>		<u>Mullens</u>		<u>Mullens W. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/28/55</u>		<u>Bessie M. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4803
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 04778 *we* 216
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Kensington</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4407 Clearbrook Lane</u>				STREET ADDRESS (If rural, give location) <u>4407 Clearbrook Lane</u>			
3. NAME OF DECEASED: (First) <u>Harry</u>		(Middle) <u>Armand</u>		(Last) <u>Cox Sr.</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>9</u> (Year) <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 13, 1876</u>	9. AGE last birthday: <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Naval Architect</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Govt. Architect</u>	11. BIRTHPLACE (State or foreign country): <u>London England</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME: <u>Harry A. Cox</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Collins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service) <u>Spanish Amer.</u>		16. SOCIAL SECURITY No.: <u>577-38-5440-A</u>		17. INFORMANT & ADDRESS: <u>Harry A. Cox Jr.</u> <u>4906-Blackfoot Rd. College Park, Md.</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				<u>Sudden</u> <u>death</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>5-10-55</u>		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)		(County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Frank J. Brockett</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-9-55</u> M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>5-12-55</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
DATE REC'D BY LOCAL REG. <u>5/10/55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>		

RECEIVED
JAN 12 1955
BUREAU V. 2

4874

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Ohio</u>	COUNTY <u>--</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>35 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lakewood</u> <u>72x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 The Clinical Center Natl. Institutes of Health</u>	STREET ADDRESS (If rural give location) <u>1673 Bunts Road</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Samuel</u>	(Middle) <u>Edward</u>	(Last) <u>Crozier</u>	<u>May 16 1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 16, 1895</u>
9. AGE last birthday: <u>59 yrs.</u>		IF UNDER 1 YEAR: Months <u>10</u> Days <u>--</u> Hours <u>--</u> Min. <u>--</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Stockman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Private industry</u>	
11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wm. Crozier</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I & II</u>		16. SOCIAL SECURITY NO. <u>297-30-7590</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>infection</u>	
IMMEDIATE CAUSE (A) <u>Cellulitis, right leg with overulcerating</u>		<u>2-3 days</u>	
ANTECEDENT CAUSE (B) <u>Aplastic anemia with</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. HOW DID INJURY OCCUR?	
M. <u>While at work</u>		Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Apr. 11, 1955</u> , to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>3:50 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Franklin B. Elough</u>		ADDRESS <u>The Clinical Center</u>	
DATE SIGNED <u>5/19/55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial - Transit</u>		DATE THEREOF <u>5-17-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Pine Hill</u>		LOCATION (City, town, or county) (State) <u>Buffalo, N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert D. Humphrey</u>		ADDRESS <u>Beth. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 23 1955

RECEIVED

4825

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Bethesda</u>		<u>35 days</u>		TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location)			
<u>50 Natl. Institutes of Health</u>				<u>Pooks Hill Apt. #303</u>			
3. NAME OF DECEASED: (First) <u>William</u>		(Middle) <u>Franklin</u>		(Last) <u>Cummins</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 3 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>December 20, 1907</u>	9. AGE last birthday <u>47 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Private industry</u>		11. BIRTHPLACE (State or foreign country): <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Cummins</u>				14. MOTHER'S MAIDEN NAME: <u>Janie Pickett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach</u>						1 yr.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Nov 15, 1954</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Ca of Stomach</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 29, 1955</u> , to <u>May 3, 1955</u> , that I last saw the deceased alive on <u>May 3</u> , 19.55, and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>For J. Childen</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>5-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>May 6, 1955</u>		DATE THEREOF <u>Mo</u>		NAME OF CEMETERY OR CREMATORY <u>Martin's Ferry, Ohio</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>5/4/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Joseph Fowler's Sons, Wash., D.C.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 6 1955

BUREAU V. S.

4896

CERTIFICATE OF DEATH

Reg. Dist. No.

215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE District of Columbia	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda (Rural)	LENGTH OF STAY (in this place) lmo 7 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.	47X-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 1003 Savannah Street, S.E.	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) Dennis	(Middle) Charles	(Last) DEAN	May 26 19 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 4-2-55
9. AGE last birthday		IF UNDER 1 YEAR Months 1 Days 24	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Charles F. DEAN		14. MOTHER'S MAIDEN NAME: Mary C. GILROY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No 4		16. SOCIAL SECURITY NO. - -	
17. INFORMANT & ADDRESS: Father Charles F. DEAN		Same as above	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Intestinal Obstruction, Duodenum			54 days
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Brain Damage			54 days
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 Apr 19 55 , to 26 May 19 55 , that I last saw the deceased alive on 26 May 19 55 , and that death occurred at 10:05 PM from the causes and on the date stated above.			
SIGNATURE D. J. PASCOE		DATE SIGNED	
D. J. PASCOE LT MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF		LOCATION (City, town, or county) (State)	
Burial		31 May 1955	
Arlington National Cemetery		Arlington, Virginia	
24. FUNERAL DIRECTOR		ADDRESS	
REGISTRAR'S SIGNATURE Mary E. Parrelly		R. A. Pumphrey Funeral Home	
DATE REC'D BY LOCAL REGISTRAR 27 May 1955		7557 Wisconsin Avenue, Bethesda, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4755

CERTIFICATE OF DEATH

Reg. Dist. No. 04782 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park Md 17</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>109 Lincoln Ave</u>				STREET ADDRESS (If rural give location) <u>109 Lincoln Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 12 1955</u>			
5. SEX: <u>M</u> 6. COLOR OR RACE: <u>C</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>				8. DATE OF BIRTH: <u>April 6, 1885</u> 9. AGE last birthday <u>70</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Public Works</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry Delaney</u>				14. MOTHER'S MAIDEN NAME: <u>Lucinda King</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Louise Delaney, 109 Lincoln Ave</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>331X</u> (A) <u>Cerebral Hemorrhage</u>						<u>36 hrs</u>	
ANTECEDENT CAUSE (B) <u>Senile Arteriosclerosis, Generalized</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2:55 PM., 1955</u> , to <u>12 May., 1955</u> , that I last saw the deceased alive on <u>12 May., 1955</u> , and that death occurred at <u>7:30 P M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. E. Jarvis</u>		ADDRESS <u>Takoma Park</u>		DATE SIGNED <u>12 May 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-16-55</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 12 1955</u>		REGISTRAR'S SIGNATURE <u>John R. Dodd</u>		24. FUNERAL DIRECTOR <u>W. E. Jarvis Co.</u>		ADDRESS <u>1432 U St. N.W.</u>	

RECEIVED
MAY 16 1955
BUREAU V. S.

4756

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Montgomery</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Takoma Park</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Takoma Park</i>		17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7600 Hammond Ave.</i>				STREET ADDRESS (If rural give location) <i>7600 Hammond Ave.</i>		1	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Gertrude Denniberg</i>				<i>May 24 1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>	8. DATE OF BIRTH: <i>April, 1880</i>	9. AGE last birthday: <i>75</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Elliot Cohen</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Mrs. Ann Landoz - 7600 Hammond Ave. Takoma Park, Md.</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Coronary Occlusion, Arteriosclerotic Heart Disease</i>				<i>Immediate</i>			
ANTECEDENT CAUSE (S) (B) <i>Arteriosclerotic Heart Disease</i>				<i>yes</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6-26</i> , 19 <i>55</i> , to <i>5-24</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>3-23</i> , 19 <i>55</i> , and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Isadore Hinkman</i>				ADDRESS <i>M.D. 915-19th St. N.W.</i>		DATE SIGNED <i>5-24-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 24, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Elisavetgrad Cemetery</i>		LOCATION (City, town, or county) (State) <i>Wash. D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 25-1955</i>		REGISTRAR'S SIGNATURE <i>J. Nelson Dodd</i>		24. FUNERAL DIRECTOR <i>O. Waryansky & Son</i>		ADDRESS <i>Wash. D.C.</i>	

MARGIN RESERVED FOR BINDING

RECEIVED

MAY 26 1955

BUREAU V. S.

487

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u> 17			
X <u>Bethesda, Rural</u>		<u>27 days</u>		STREET ADDRESS (If rural give location) <u>1100 Linden Ave., Apt 201</u> 1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
(Type or Print) <u>Ellsworth Calvin DE VAUGHN</u>		<u>May 29 1955</u>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>27 October 1893</u>	<u>61 yrs.</u>	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Govt Employee</u>		<u>U. S. Govt</u>		<u>Washington, D.C.</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Walter C. DE VAUGHN</u>				<u>Jane F. BERNISTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u> (If Yes, give war or dates of service) <u>WWI WWII</u>		<u>Unknown</u>		<u>10608 Edgewood Ave., Walter C. DE VAUGHN Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						<u>1 day</u>	
ANTECEDENT CAUSE (S) <u>Coronary occlusion, right coronary</u>						<u>1 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2 May</u> , 19 <u>55</u> , to <u>29 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>29 May</u> , 19 <u>55</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. H. CARY LT MC</u>				ADDRESS <u>USN U. S. Naval Hospital M. D. NMMC, Bethesda, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1 June 1955</u>		<u>Arlington National Cemetery</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>30 May 1955</u>		<u>Mary E. Parrelly</u>		<u>Hines Funeral Home</u>		<u>2901 14th Street, N.W., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4878

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04785

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY <u>471-3</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
TOWN <u>SILVER SPRING</u>		TOWN <u>WASHINGTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BOSWELL NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>3319 FESEN DEN ST. N.W.</u>	
92 122 STREET ADDRESS <u>14511 COLESVILLE RD.</u>			
3. NAME OF DECEASED (First) <u>NELLIE</u> (Middle) <u>VINCENT</u> (Last) <u>DISHMAN</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>29</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>29 FEB. 1871</u>
			9. AGE last birthday <u>84</u> yrs. If under 1 year Months <u>2</u> Days <u>29</u> If under 24 hrs. Hours <u>29</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>ALEXANDRIA VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM VINCENT</u>		14. MOTHER'S MAIDEN NAME <u>SINA SIMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT AND ADDRESS <u>EUSTACE M. PEIXOTTO</u> <u>3319 FESEN DEN ST. N.W. WASHINGTON, D.C.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>BRONCHOPNEUMONIA</u>			<u>2 1/2 mos.</u>
Antecedent cause(s) (b) <u>SENILITY</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTIOSCLEROSIS</u>			
(c) <u>PARKINSONISM</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>N.A.</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>N.A.</u>	
SUICIDE		INJURY	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>N.A.</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>OCT 25, 1952</u> to <u>MAY 29, 1955</u> , that I last saw the deceased alive on <u>MAY 29, 1955</u> , and that death occurred at <u>6 40 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>David C. White</u>		ADDRESS <u>Walter Reed Army Hosp. 29 May 55</u>	
DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>5/29/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State) <u>Alexandria, Va.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
DATE REC'D BY LOCAL REG. <u>5-31-55</u>		REGISTRARS SIGNATURE <u>Francis Totten</u>	
		FUNERAL DIRECTOR <u>Josiah S. Evelyn</u>	
		ADDRESS <u>Alex. Va.</u>	
		met. No. <u>827</u>	

BUREAU V. S.

JUN 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4899

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04786 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Olney</u>		<u>3 days</u>		OR TOWN <u>Brookeville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Montgomery County General Hospital, Inc</u>		STREET ADDRESS (If rural give location)			
73							
3. NAME OF DECEASED: (Type or Print)		(First) <u>William</u>		(Middle) <u>Henry</u>		(Last) <u>Dowling</u>	
				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>25</u> <u>19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>3/16/1892</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>George E. Dowling</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Efford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS: <u>Hospital Record</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Acute Massive Pulmonary Edema</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B) <u>Congestive Heart Failure</u>						<u>6 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive Heart Disease</u>						<u>5-6 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 24, 1955</u> , to <u>May 25, 1955</u> , that I last saw the deceased alive on <u>May 24, 1955</u> , and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Richard A. Yates</u>		M. D. <u>Olney, Md.</u>		DATE SIGNED <u>5/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parkland</u>		LOCATION (City, town, or county) (State) <u>Brookeville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-28-55</u>		REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>		24. FUNERAL DIRECTOR <u>Roy W. Barker</u>		ADDRESS <u>Luptonville</u>	

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JUN 2 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Pr Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sakoma Park</u> LENGTH OF STAY (in this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hyattsville, Md.</u> 16152	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>708 Philadelphia Ave.</u>		STREET ADDRESS (If rural, give location) <u>6103 Eastern Ave. Apt 102 N</u>	
3. NAME OF DECEASED (First) <u>JESSIE</u> (Middle) <u>A.</u> (Last) <u>EARMAN</u>		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>19</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG. 25, 1872</u>
9. AGE last birthday <u>82 yrs.</u>		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>PRINCE EDWARD ISLAND, CANADA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN MAC DONALD</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET PERCIVALE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT <u>Mrs. Louise Coffman, 6103 Eastern Ave. Hyatts. Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>(1) Cerebral Thrombosis</u>		
(b) Antecedent cause(s) <u>(2) Generalized Arteriosclerosis</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>(3) Cerebro-sclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)		(COUNTY)
(STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>
HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 17, 1955 to May 19, 1955, that I last saw the deceased alive on May 17, 1955, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

RECEIVED

MAY 23 1955

BUREAU V. S.

4811

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Chevy Chase</u>		LENGTH OF STAY (in this place) <u>One year</u>		CITY (If outside corporate limits, write TOWN and give nearest town) <u>Chevy Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4757 Chevy Chase Drive</u>				STREET ADDRESS (If rural give location) <u>4757 Chevy Chase Drive</u>			
3. NAME OF DECEASED: (First) <u>Martha</u> (Middle) <u>K.</u> (Last) <u>EIKER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>1</u> <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 8, 1898</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Oscar King</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Chandler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Karl V. Eiker-Same Item #2</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>467.1 cerebral vascular accident</u>						<u>10 wks.</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>familial telangiectasia</u>						<u>congenital</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>coronary artery disease</u>						<u>5 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 6, 1955</u> , to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>May 1, 1955</u> and that death occurred at <u>12:47 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>6852 16 1/2 W. Wall St.</u>		DATE SIGNED <u>5/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/3/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/4/55</u>		REGISTRAR'S SIGNATURE <u>Bernice M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 5 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4810 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04788

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH: <i>Montgomery</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<i>X</i> TOWN <i>Rural - Rockville</i>	<i>35 years</i>	TOWN	<i>X</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7 Locks Road</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Emily Blandford Elgin</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>5/30</i> 19 <i>55</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>September 17/1911</i>
9. AGE last birthday <i>43</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>13</i>	IF UNDER 24 HRS. Hours <i>13</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <i>Housewife</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>Montgomery</i>		13. FATHER'S NAME: <i>Douglas M. Blandford</i>	
14. MOTHER'S MAIDEN NAME: <i>Emily Yellow</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS: <i>John E. Elgin - Box 483 - Rockville Md</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Carcinoma of right breast,</i>			<i>4 1/2 years</i>
DUE TO			
ANTECEDENT CAUSE (B) <i>with metastasis to lungs.</i>			
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>			
19A. DATE OF OPERATION: <i>October 19 50</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Carcinoma of right breast</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1950</i> , to <i>May 30, 1955</i> , that I last saw the deceased alive on <i>May 30, 1955</i> , and that death occurred at <i>1 P. M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Wm. H. Kuthman</i>		ADDRESS <i>Rockville Md.</i> DATE SIGNED <i>May 30/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>June 2/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Monacacy</i>		LOCATION (City, town, or county) (State) <i>Beallsville - Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/31/55</i>		REGISTRAR'S SIGNATURE <i>Laurel H. Gindup</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>Rockville Md</i>	

BUREAU V. S.

JUN 1 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4812 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04790

CERTIFICATE OF DEATH

Reg. Dist. No. 216

item 7, Film G182 6-7-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>5/19/55 - 5/21/55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>	STREET ADDRESS (If rural give location) <u>Route #1</u>		
3. NAME OF DECEASED: (Type or Print) <u>First: Daniel (Middle) Evans (Last)</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 21, 1955</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>5/4/76</u>
9. AGE last birthday <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Whitman, Clarence</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Wales</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>David Evans</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-6199</u>	
17. INFORMANT & ADDRESS: <u>Alvin L. Evans</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Infarct</u>			<u>24 hours</u>
ANTECEDENT CAUSE (S) DUE TO <u>Coronary Thrombosis</u>			<u>6 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u> (C) <u>Arteriosclerotic-Cardiovascular Disease</u>			<u>10 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>			<u>12 years</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11 May, 1955</u> , to <u>21 May, 1955</u> , that I last saw the deceased alive on <u>21 May, 1955</u> , and that death occurred at <u>6:50 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John W. Smith</u>		ADDRESS <u>Barnesville</u> DATE SIGNED <u>21 May 55</u>	
M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/29/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>William B. Hilton</u>		ADDRESS <u>Barnesville Md</u>	

RECEIVED

MAY 31 1955

BUREAU V. S.

4813

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Bethesda Rural</u>		<u>10hrs 25 min</u>		<u>Arlington</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>5</u> <u>U. S. Naval Hospital</u>				<u>2801 North Somerset Street</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH:			
<u>Clifton</u> <u>Joseph</u> <u>FALCON</u>		<u>4</u> <u>May</u> <u>19 55</u>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>9-4-01</u>	<u>53</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Mariner</u>		<u>Mariner Retired</u>		<u>Louisiana</u>		<u>US</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Simon FALCON</u>				<u>DRALIN ALLMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		15. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>Yes</u> ✓ <u>WW II Korea</u>		<u>579 44 7039</u>		<u>Mrs. Mary E. FALCON (WIFE)</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)						<u>3 days</u>	
<u>420.1</u> <u>Coronary thrombosis</u>							
ANTECEDENT CAUSE (B)						<u>years</u>	
<u>coronary artery</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
DUE TO <u>sclerosis</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3 May</u> , 1955, to <u>4 May</u> , 1955, that I last saw the deceased alive on <u>4 May</u> , 1955, and that death occurred at <u>5:25A</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. E. Flipse</u>				ADDRESS		DATE SIGNED	
<u>M. E. FLIPSE</u> <u>LCDR, MC, USN</u>				<u>M. D.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6 May 1955</u>		<u>Arlington National Cemetery</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4 May 1955</u>		<u>Mary E. Parrelly</u>		<u>R. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 9 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4814

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04792

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>District of Columbia</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Bethesda Rural</u>	LENGTH OF STAY (in this place) <u>10 mo 25 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	<u>47X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural give location) <u>3120 38th Street, N.W.</u>	✓
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Walton Canby FERRIS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 9 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12-2-00</u>
9. AGE last birthday <u>54 yrs.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>U.S. Govt</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>State Department</u>	11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME: <u>Walter FERRIS</u>	
14. MOTHER'S MAIDEN NAME: <u>Hannah PRICE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Wife Mrs. Sarah FERRIS Same as above</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Asphyxia, Brain</u>			<u>2 yrs.</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>15341954 3</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Brain tumor</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>14 June, 19 54</u> to <u>9 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9 May</u> , 19 <u>55</u> , and that death occurred at <u>12:10 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>R. W. MACKIE</u>		ADDRESS <u>MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>11 May 55</u>	
NAME OF CEMETERY OR CREMATORY <u>Prince George County Crematory</u>		LOCATION (City, town, or county) (State) <u>Maryland and Interment Rock Creek Park Cemetery Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9 May 1955</u>		REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>	
24. FUNERAL DIRECTOR <u>Gawlers Funeral Home</u>		ADDRESS <u>1756 Penn Avenue, Washington, D.C.</u>	

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4815 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04793

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>BETHESDA</u>		<u>2 days</u>		TOWN <u>SILVER SPRING, MD. 56</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>74</u> <u>SUBURBAN HOSPITAL</u>				<u>213 CRESTMOOR CIRCLE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>ROBERT I FOSTER</u>				<u>MAY 25 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>4/27/89</u>	<u>66</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Salesman</u>				<u>Real Estate</u>		<u>North Carolina</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Felix A. Foster</u>				<u>Fannie Phifer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
						<u>Mrs. Neely Foster</u> <u>213 Crestmoor Circle, Silver Spring, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X			(A) <u>Cerebral Thrombosis</u>				<u>5 DAYS</u>
IMMEDIATE CAUSE			DUE TO				
ANTECEDENT CAUSE (S)			(B) <u>Cerebral Arteriosclerosis</u>				<u>1 yr</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			DUE TO				
(260X)			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Diabetes Mellitus.</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James A. Roberts</u>				ADDRESS <u>5907 Geo. Ave. Silver Spring, Md.</u>		DATE SIGNED <u>May 25, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-28-55</u>		<u>H. Lincoln</u>		<u>Pr. Geo. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/28/55</u>		<u>Bessie M. Thompson</u>		<u>Deaf Funeral Home</u>		<u>Wash. D. C.</u>	

BUREAU V. S.

MAY 31 1965

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Calif</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Gabobba Park</i>		LENGTH OF STAY (in this place) <i>10 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Claremont</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Sanitarium</i>				STREET ADDRESS (If rural give location) <i>760 West 9th St.</i>			
3. NAME OF DECEASED: (First) <i>John</i> (Middle) <i>A.</i> (Last) <i>Fritz</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>May 7 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>SEPT. 11, 1903.</i>	9. AGE last birthday: <i>51</i> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.) <i>SALES MANAGER</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>SOUND-STATE DIST. INC</i>		11. BIRTHPLACE (State or foreign country): <i>WISCONSIN</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>HENRY FRITZ</i>				14. MOTHER'S MAIDEN NAME: <i>LOUISE BARTO</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk. (If Yes, give war or dates of service)) <i>no</i>		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <i>MRS JOHN FRITZ 760 W. 9th St. CLAREMONT, CALIF</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cerebrovascular Accident</i>						<i>24 days</i>	
ANTECEDENT CAUSE (S) (B) <i>Arteriosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Terminal uremia</i>							
19A. DATE OF OPERATION: <i>1 May 55</i>		19B. MAJOR FINDINGS OF OPERATION: <i>No cause for intestinal obstruction found</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Apr 13, 1955</i> to <i>May 7, 1955</i> , that I last saw the deceased alive on <i>May 7, 1955</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS <i>M.D. 2902 Porter St. N.W. Wash. D.C.</i> DATE SIGNED <i>May 7, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial - Transvaal</i>		DATE THEREOF <i>May 12, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Pomona Cemetery</i>		LOCATION (City, town, or county) (State) <i>Pomona Calif.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 7 1955</i>		REGISTRAR'S SIGNATURE <i>J. William Dodd</i>		24. FUNERAL DIRECTOR <i>254 Canal St. N.W. Takoma Park 12, D.C.</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4759 CERTIFICATE OF DEATH

04795

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Fr. Geo.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <i>Takoma Park</i>		3 days		OR TOWN <i>Hyattsville</i> 16-15-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
75 <i>Washington Sanitarium & Hosp</i>				3040 <i>Powder Mill Road</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Ida Louise Fuller</i>				<i>5-24-1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>F.</i>	<i>W.</i>	<i>Married</i>	<i>9-4-1885</i>	<i>69</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>				<i>Md.</i>		<i>U.S.-9.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Clarence Bond</i>				<i>Elizabeth L. Turner</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>No</i>						<i>Washington Sanitarium & Hospital Records</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
201X IMMEDIATE CAUSE							
(A) DUE TO <i>Malignant lymphoma,</i>							
ANTECEDENT CAUSE (S) <i>probable Hodgkin type</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<i>3 Sept 1954</i>		<i>Splenectomy</i>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year)		21E. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 3, 1952</i> to <i>May 24, 1955</i> , and that death occurred at <i>10:35 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>John F. Brunsberger</i>				ADDRESS <i>M.D. Takoma Park - Takoma</i>		DATE SIGNED <i>5-24-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 27, 1955</i>		<i>London Park Cemetery</i>		<i>Baltimore</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>May 24-1955</i>		<i>J. Nelson Dodd</i>		<i>J. Arthur Halber</i>		<i>254 Central St. N.W. Wash. D.C.</i>	

CERTIFICATE OF DEATH

NAME		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		MARRIAGE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	

BUREAU V. S.

MAY 26 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4816

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

04796

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>1014 Merrimac Drive</u>		STREET ADDRESS (If rural give location)		<u>1014 Merrimac Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Corinne Newman Gaskins</u>				<u>May 25 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>3-29-1861</u>	<u>94</u> yrs.	Months <u>1</u>	Days <u>26</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>			<u></u>		<u>Orange, Virginia</u>		<u>U.S.</u>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James Newman</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>4</u> No		<u>None</u>		<u>Daughter-Mrs. Dorothy P. Trayfors</u> <u>1014 Merrimac Dr. SS Md</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>450.0</u> <u>Immediate cause</u>							
(a) DUE TO							
<u>Antecedent causes (s)</u> <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</u>							
(b) DUE TO							
<u>Suppression of</u> <u>Calcium Secretion</u> <u>"Hypoparathyroidism"</u> <u>Since 3 yrs.</u>							<u>20 yrs</u>
(c) DUE TO							
<u>Coronary Sclerosis</u>							<u>6 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
<u>8</u>				<u></u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
<u></u>		<u></u>		<u></u>		<u></u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
<u></u>		<u></u>		<u></u>			
22. I hereby certify that I attended the deceased from <u>January 19 51</u> , to <u>May 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>55</u> , and that death occurred at <u>1:40</u> , from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
<u>Thomas J. Quinn</u>		<u>M.D.</u>		<u>1014 Merrimac Dr.</u>		<u>5/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-27-55</u>		<u>Catlett Cemetery</u>		<u>Fauquier Co. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 27/55</u>		<u>Frances Toller</u>		<u>Robert A. Camphrey</u>		<u>Bethesda, Md.</u>	

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04797

4817

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL) <u>Bethesda</u> OR TOWN <u>Bethesda</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STATE <u>Montgomery</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> OR TOWN <u>Silver Spring</u> STREET ADDRESS (If rural give location) <u>2010 Janier Drive</u>			
3. NAME OF DECEASED: (Type or Print) <u>Ovilup H. George</u>				4. DATE OF DEATH: <u>May 17 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 28, 1878</u>	9. AGE last birthday: <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Maintenance Div. Print. Off.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Gov. Print. Off.</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
13. FATHER'S NAME: <u>Henry George</u>				14. MOTHER'S MAIDEN NAME: <u>Pauline Page</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-30-3500</u>		17. INFORMANT & ADDRESS: <u>Mrs. Hazel Hazell</u> <u>1904 Janier St. Silver Spring, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>						10 days	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						—	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) —							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —							
19A. DATE OF OPERATION: <u>None</u>				19B. MAJOR FINDINGS OF OPERATION: —			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 1950</u> to <u>May 17 1955</u> that I last saw the deceased alive on <u>May 17, 1955</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Marion Bausch</u>		M. D. <u>9245 Col. Blvd. Silver Spring, Md.</u>		DATE SIGNED <u>5/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warner & Pumphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU V. S.

MAY 28 1955

RECEIVED

4818

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write OR and give nearest town) Silver Spring LENGTH OF STAY (in this place) 2 weeks
 TOWN Silver Spring
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenmont-Colesville Rd
40 Frank Robbins

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Prince George's
 CITY (If outside corporate limits, write RURAL and give nearest town) Takoma Park
 OR TOWN Takoma Park 16-17-2
 STREET ADDRESS (If rural give location) 7306 Flower Ave

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HenryGlenwright

4. DATE OF DEATH:

(Month)

(Day)

(Year)

5-20-1955.

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MaleWMarriedAPRIL 27- 1868.87 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

MinerEnglandU.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Henry GlenwrightMary Atkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

4 No-Carol G. Robbins, daughter 7306 Flower Ave Takoma Park, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X

Immediate cause

(a)

BRONCHOPNEUMONIA

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

CEREBRAL ARTERIO SCLEROSIS

DUE TO

(c)

Interval Between Onset And Death

3 DAYS5 YEARS

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 5-17-1955, to 5-20-1955, that I last saw the deceasedalive on 5-18-1955, and that death occurred at 5-20-55 6 PM

SIGNATURE

(Degree or title)

from the causes and on the date stated above.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial May 24, 1955 Prospect Cemetery Mansfield, Tioga Co. Penna.
5-23-55 Frances Potter 8726 Colesville Rd Silver Spring, Md 254 Carroll St. N.W. Takoma Park 12, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 26 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4819
CERTIFICATE OF DEATH

04799

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Damascus</u>		LENGTH OF STAY (in this place) <u>9 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Damascus</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # 3 Mt. Airy</u>				STREET ADDRESS (If rural give location) <u>R.F.D. #3 Mt. Airy</u>		<u>1</u>	
3. NAME OF DECEASED: (First) <u>Mary</u>		(Middle) <u>Catherine</u>		(Last) <u>Gobble</u>		4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>23</u> (Year) <u>19 55</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>		8. DATE OF BIRTH: <u>June 16, 1882</u>	
9. AGE last birthday: <u>72</u> yrs.		10. MONTHS <u>72</u>		11. BIRTHPLACE (State or foreign country): <u>Sneedville, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Sneedville, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Andrew J. Crick</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Buckles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>4 No</u>		16. SOCIAL SECURITY No.: <u>--</u>		17. INFORMANT & ADDRESS: <u>James E. Gobble, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>502.0</u> Immediate cause						<u>2 years</u>	
(a) <u>Arteriosclerotic cardiovascular disease</u>							
DUE TO							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.						<u>7 years</u>	
(b) <u>Chronic bronchitis & emphysema</u>							
DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 2, 1951</u> , to <u>May 13, 1955</u> , that I last saw the deceased alive on <u>May 13, 1955</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James E. Kerr M.D.</u>				ADDRESS <u>Damascus, Md.</u> DATE SIGNED <u>5/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 26, 1955</u>		<u>Pleasant Hill</u>		<u>Monrovia, Fred. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 23, 1955</u>		<u>Della M. Burdette</u>		<u>Orin L. Molesworth</u>		<u>Damascus, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 31 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04800

4760 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District</u> COUNTY of <u>Columbia</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>17 TOWN Takoma Park</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>175 Wash. San. & Hosp.</u>				STREET ADDRESS (If rural give location) <u>5014 42nd St N.W.</u> ✓			
3. NAME OF DECEASED: (Type or Print) <u>Charles Rupert Grantham</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 3 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Sept. 16, 1899</u>	
				9. AGE last birthday: <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Mississippi</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charlie A. Grantham</u>				14. MOTHER'S MAIDEN NAME: <u>Nora Shaws</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Wash. San. & Hosp. Records.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
465X IMMEDIATE CAUSE (A) <u>Massive embolism, pulmonary arteries</u>						Terminal	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Recent Infarct, lower lobe of rt. lung</u>						few days	
19A. DATE OF OPERATION: <u>26 April '55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Vein stripping for varicosities, left lower extremity</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-25-55</u> 19... to <u>5-3-55</u> 19..., that I last saw the deceased alive on <u>5-3-55</u> , 19..., and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Arthur E. Coyle M.D.</u>				ADDRESS <u>M. D. Takoma Park Md</u> DATE SIGNED <u>5-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 5 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Urbington Natl Cem</u>		LOCATION (City, town, or county) (State) <u>Washington</u> <u>DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 4 1955</u>		REGISTRAR'S SIGNATURE <u>William D. Cold</u>		24. FUNERAL DIRECTOR <u>Chapman Funeral Home</u>		ADDRESS <u>Wash. DC</u>	

RECEIVED

MAY 6 1955

BUREAU V. S.

4820

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MARYLAND</u> COUNTY <u>MONT</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X Kensington Md.</u>	LENGTH OF STAY (in this place) <u>1947-1955 8 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chevy Chase</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Kensington Gardens Kensington Md.</u>	STREET ADDRESS (If rural give location) <u>4572 Stanford St</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>MARY B GREENWAY</u>		<u>5 9 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec 17 1865</u>
9. AGE last birthday: <u>89</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Madison, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Thomas J. Turpin</u>		14. MOTHER'S MAIDEN NAME: <u>Ann McJulien</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mr. Geo. E. Greenway, 4412 Stanford St. Chevy Chase, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>443X</u>		<u>5 years</u>	
ANTECEDENT CAUSE (S):		<u>1 month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Hypertensive heart disease</u>			
(B) <u>Hepatitis</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>47</u> , to <u>May 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 8</u> , 19 <u>55</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. Joseph Kenney</u>		ADDRESS <u>6450 Wisconsin Ave, Bldg. 2nd</u>	
DATE SIGNED <u>5-10-55</u>		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Trans. & Burial</u>		DATE THEREOF <u>5/9/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Lakewood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Jackson, Mississippi</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-10-55</u>		REGISTRAR'S SIGNATURE <u>Francis P. Warner</u>	
24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 13 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4821

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04802

Reg. Dist. No. 217

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <u>Herbert</u>		(Middle) <u>Lee</u>		(Last) <u>Harding</u>	
4. DATE OF DEATH		(Month) <u>MAY</u>		(Day) <u>16</u>		(Year) <u>1955</u>	
5. SEX <u>m.</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>9/28/1889</u>	9. AGE last birthday <u>65</u> yrs.	If under 1 year Months	If under 24 hrs. Days	If under 1 year Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter-Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Granville Harding</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine Williams.</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY No. <u>213-05-8588</u>				17. INFORMANT AND ADDRESS <u>Mrs. Herbert Harding, Sandy Spring Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>(a) Coronary Thrombosis</u>						<u>15 min.</u>	
Antecedent cause(s) <u>(b) Hypertensive Cardiovascular Disease</u>						<u>4 years.</u>	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <u>(c)</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 22</u> , 19 <u>55</u> , to <u>5/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/14</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>JM21</u>		(Degree or title)		ADDRESS <u>Sandy Spring, Maryland</u>		DATE SIGNED <u>5/18/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>May 19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Dominican Brothers Cemetery</u>		LOCATION (City, town, or county) <u>Montgomery Co Md</u>	
DATE REC'D BY LOCAL REG. <u>5-19-56</u>		REGISTRAR'S SIGNATURE <u>Herminie B. Lawler</u>		24. FUNERAL DIRECTOR <u>Roy W. Barber</u>		ADDRESS <u>Johnville Md</u>	

RECEIVED

MAY 23 1955

BUREAU V. S.

4822

04803

CERTIFICATE OF DEATH

Reg. Dist. No. 276

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Bethesda</u>		<u>60 days</u>		TOWN <u>Wheaton</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50</u> <u>The Clinical Center</u> <u>National Institutes of Health</u>				<u>11701 Grandview Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Rosanna</u> <u>--</u> <u>Harns</u>				<u>May</u> <u>1</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>October 8, 1920</u>	<u>34 yrs.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>-- Own Home</u>		<u>Pennsylvania</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joseph Musgrove</u>				<u>Hazel Ammon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>4</u> <u>No</u> (If Yes, give war or dates of service) <u>--</u>		<u>None</u> <u>Not Available</u>		<u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Acute lymphocytic leukemia</u> <u>3 mos</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Staphylococcus aureus septikemia</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<u>-2</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 2</u> , 19 <u>55</u> , to <u>May 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>55</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Horace W. Burton</u>		<u>The Clinical Center</u> <u>National Institutes of Health</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 4, 1955</u>		<u>Parklawn Cemetery</u>		<u>Rockville Pike, Montg. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5/4/55</u>		<u>Bessie M. Thompson</u>		<u>Warner E. Humphrey</u>		<u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 6 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4823

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md.

04804

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cabin John</u>				TOWN <u>Cabin John</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6424-79th St.</u>				STREET ADDRESS (If rural give location) <u>6424-79th St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
MYRTLE A HILL				MAY 19 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: June 30, 1888	
9. AGE last birthday: 66 yrs.		10. BIRTHPLACE (State or foreign country): Cropley Maryland		11. CITIZEN OF WHAT COUNTRY? US			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife				10b. KIND OF BUSINESS OR INDUSTRY: Housewife			
13. FATHER'S NAME: William T. Redden				14. MOTHER'S MAIDEN NAME: Isabelle Pennfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No.: None			
17. INFORMANT & ADDRESS: Husband - 6424-79th St. Cabin John, Md.							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
191X Immediate cause <u>Melanotic adenocarcinoma of cerebrum</u> DUE TO <u>adenocarcinoma of sebaceous gland of left cheek with multiple subcutaneous metastasis and to lung right</u>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 1 6-12-53				19b. MAJOR FINDINGS OF OPERATION: Adenocarcinoma of sebaceous gland left cheek.			
21. ACCIDENT SUICIDE HOMICIDE (Specify) -				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
PLACE (Home, farm, factory, street, office bldg., etc.)				(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY - m.				INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from 6:30, 1954, to MAY 18 1955, that I last saw the deceased alive on MAY 18, 1955, and that death occurred at 4:10 PM, from the causes and on the date stated above.							
SIGNATURE <u>C. P. Ryland</u>				ADDRESS <u>4400 49th St., N. W. Washington 16, D. C.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>5/23/55</u>			
NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>				LOCATION (City, town, or county) <u>Montg. Co. Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5/21/55</u>				REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Md.</u>			

RECEIVED

MAY 24 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4824
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04805
 Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Germanstown</u>		<u>10 yrs</u>		TOWN <u>Germanstown</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. # 2</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. # 2</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>William</u>				<u>Hoes</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>cal</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Sept 13, 1913</u>	
9. AGE last birthday: <u>41</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Ernest Hoes</u>				14. MOTHER'S MAIDEN NAME: <u>Delia Corn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>World War II</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Woodrow Hoes, Germanstown, Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>						<u>Found dead in floor of his bedroom</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-5-55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		LOCATION (City, town, or county) (State) <u>Brownstown, Md</u>	
DATE REC'D BY LOCAL REG. <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Kraybill</u>		24. FUNERAL DIRECTOR <u>Robert L. Snower</u>		ADDRESS <u>Pockville, Md</u>	

BUREAU V. S.

MAY 10 1955

RECEIVED

4825

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Alexandria</u>	
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>13 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Alexandria</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>The Clinical Center</u>				STREET ADDRESS (If rural give location) <u>915 N. Alfred Street</u>			
3. NAME OF DECEASED: (First) <u>Lydia</u>		(Middle) <u>Belle</u>		(Last) <u>Holmes</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May 1 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>January 12, 1931</u>	
9. AGE last birthday: <u>24</u> yrs.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>John Evans</u>		14. MOTHER'S MAIDEN NAME: <u>Roberta Whitehurst</u>		15. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	
16. SOCIAL SECURITY NO. <u>Not Available</u>		17. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congenital heart disease</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Hydropericardium</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Congestion of the lungs and liver</u>							
DUE TO <u>Partially healed closure of patent interatrial septal defect</u>							
(C) <u>Partially healed surgical incision of thorax</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fibrous adhesions about the Fallopian tubes and scattered over the small intestines</u>							
19A. DATE OF OPERATION: <u>3 4-21-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Interatrial septal defect</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>--</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-- M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work <u>--</u>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>April 18 1955</u> , to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>May 1, 1955</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Andrew G. Monow</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>5/2/55</u>		M. D. <u>National Institutes of Health</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Natl</u>		LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/2/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>L.A. Lewis</u>		ADDRESS <u>800 Wolfe St. Alex. Va</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 5 1955

BUREAU V. S.

4826

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery MARYLAND		STATE Virginia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Alexandria	
TOWN Bethesda Rural		TOWN Alexandria	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 811 North Overlook Drive	
3. NAME OF DECEASED: (First) (Middle) (Last) Douglas (n) HOUSER		4. DATE (Month) (Day) (Year) OF DEATH: May 30 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 5-30-55
9. AGE last birthday 2 yrs. 33 Months 3 Days 3 Hours 3 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	
11. BIRTHPLACE (State or foreign country): Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: William D. HOUSER		14. MOTHER'S MAIDEN NAME: Betty L. WORRALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Father CDR William D. HOUSER Same as above		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Prematurity		2hr. 33 min.	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 30 May, 1955 , to 30 May, 1955 , that I last saw the deceased alive on 30 May, 1955 , and that death occurred at 5:15A M, from the causes and on the date stated above.			
SIGNATURE M. S. Allen		DATE SIGNED	
M. S. ALLEN, M.D., U.S. Naval Hospital, Bethesda, Maryland			
23. BURIAL OR CREMATION, DATE, PLACE, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR ADDRESS	
Burial 8 June 1955 Arlington National Cemetery Arlington, Virginia		Cunningham Funeral Home Alexandria, Virginia	
DATE REC'D BY LOCAL REGISTRAR 2 June 1955		REGISTRAR'S SIGNATURE Mary E. Parrelly	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 3 1955

RECEIVED

4827

CERTIFICATE OF DEATH

Reg. Dist. No.

04808
296

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>W. Virginia</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>53</u> days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Belle, West Virginia</u> <u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50</u> <u>The Clinical Center</u> <u>National Institutes of Health</u>		STREET ADDRESS (If rural give location) <u>1831 West Dupont</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Dana</u> <u>M.</u> <u>Huddleston</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>10</u> <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6 Dec/ 1891</u>
9. AGE last birthday <u>63</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	
11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Huddleston</u>		14. MOTHER'S MAIDEN NAME: <u>Georgia Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>W.W. I</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <u>160X</u> (A) <u>Massive pulmonary embolus</u>			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Epidermoid carcinoma of right maxillary sinus with extension through to cranial cavity</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>24 May 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Epidermoid carcinoma of right maxillary sinus.</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 18, 1955</u> , to <u>May 10, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>3:35 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James A. Pittman</u>		DATE SIGNED <u>May 10, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL - 5-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>MONTGOMERY MEM. PARK</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/12/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>A. H. Hines Co., Washington, D.C.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 16 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4828

04809

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4612 Montgomery Ave.</u>		STREET ADDRESS (If rural give location) <u>4612 Montgomery Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>ANNIE</u> <u>HUDGINS</u>		DEATH: <u>May 18,</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 3, 1857</u>
9. AGE last birthday <u>97</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>16</u> Hours <u>16</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Andrew Cottee</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Ida C. Poole- Item# 2</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROTIC CARDIO</u>		<u>YEARS</u>	
ANTECEDENT CAUSE (S) <u>VASCULAR DISEASE</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Acute Hemorrhagic Cystitis</u>		<u>one wk.</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 17, 1955</u> to <u>May 18, 1955</u> , that I last saw the deceased alive on <u>May 17, 1955</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>DeWitt E. DeLawter</u>		DATE SIGNED <u>5/18/55</u>	
M. D. <u>8025 Aberdeen Rd Bethesda Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-21-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

MAY 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4829 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04810			
CERTIFICATE OF DEATH			
Reg. Dist. No. 215			
Item 9, Film G181 5-18-55 et			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>DC</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Bethesda Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> <u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		STREET ADDRESS (If rural give location) <u>Westchester Apts</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William</u> <u>Lambert</u> <u>Huggins Jr.</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>7</u> <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH: <u>17 Jun 1902</u>
9. AGE last birthday <u>52</u> <u>53</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Public Relations Railroad</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William L. HUGGINS</u>		14. MOTHER'S MAIDEN NAME: <u>Emma SPOHR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>2/42 - 9/45</u>		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <u>Son: William L. HUGGINS 504 W Garden Rd. Oreland, Penna.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Brain tumor, left cerebrum</u>			<u>7 months</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>28 Dec 1954</u>		19B. MAJOR FINDINGS OF OPERATION <u>No evidence of tumor</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>23 Feb., 1955</u> , to <u>7 May, 1955</u> , that I last saw the deceased alive on <u>7 May</u> , 19 <u>55</u> , and that death occurred at <u>6:25</u> M, from the causes and on the date stated above.			
SIGNATURE <u>E.P. THELEN</u>		ADDRESS <u>M.D. NMHC, Bethesda, Maryland</u>	
DATE SIGNED <u>7 May 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Chambers Funeral Home, Washington, D.C.</u>		ADDRESS <u>3072 M St. N.W.</u>	

BUREAU V. S.

MAY 16 1955

RECEIVED

4830

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Loudoun</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rural</u>		LENGTH OF STAY (in this place) <u>8 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Round Hill</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>- -</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Arthur</u> <u>(n)</u> <u>INGERSOLL</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>21</u> <u>19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>4-24-67</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>School Teacher</u>		11. BIRTHPLACE (State or foreign country): <u>Massachusetts</u>	
13. FATHER'S NAME: <u>Thomas Ingersoll</u>				14. MOTHER'S MAIDEN NAME: <u>Mehitable Waterhouse</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Son Stuart H INGERSOLL</u> <u>Same as above</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia, organism unknown</u> <u>2 weeks</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 May, 1955</u> , to <u>21 May</u> , 1955, that I last saw the deceased alive on <u>21 May</u> , 1955, and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>P. G. BAMBERG LT MC USN</u>				ADDRESS <u>Pg. Bowling</u>			
DATE SIGNED <u>23 May 1955</u>				DATE SIGNED <u>U.S. Naval Hospital, NMMC, Bethesda, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>24 May 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory Prince George Co, Maryland</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>23 May 1955</u>		REGISTRAR'S SIGNATURE <u>Mary C. Parrelly</u>		24. FUNERAL DIRECTOR <u>R. A. Pumphrey Funeral Home</u>		ADDRESS <u>7557 Wisconsin Ave. Bethesda, Maryland</u>	

RECEIVED

MAY 26 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1804812

4831

CERTIFICATE OF DEATH

Reg. Dist. No. 213

Item 7, Film G182 6-7-55 et

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) Darnestown LENGTH OF STAY (in this place) 18 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Saithsburg, R. 7. D. #3

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgo.
CITY (If outside corporate limits, write RURAL and give nearest town) Darnestown
STREET ADDRESS (If rural give location) Saithsburg, R. 7. D. #3

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

HARRYJOPPY

4. DATE OF DEATH:

(Month)

(Day)

(Year)

May311955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

malecoloredMarriedMay 30, 189362 yrs. 62 yrs. 31 days 19 hours 55 min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X
Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 May, 1955 to 31 May 1955, that I last saw the deceasedalive on 31 May, 1955, and that death occurred at 6 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REBURY (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

John S. Lawrence, M.D.BoydMay 31, 1955Burial 6/2/55 Lincoln Park Rockville, Md6/2/55 Laurel H. HagloepRobert L. Snowden Rockville, Md

BUREAU V. S.

JUN 3 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4761

CERTIFICATE OF DEATH

Reg. Dist. No. 0481223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sapona Park</u>	LENGTH OF STAY (in this place) <u>29 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sapona Park</u>	<u>17</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7305 Holly Avenue</u>		STREET ADDRESS (If rural give location) <u>7305 Holly Avenue</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last) <u>PERRY LESLIE KEEFER</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>May 4 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>November 16, 1880</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Apprentice</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S. GOVT. SERVICE</u>	
11. BIRTHPLACE (State or foreign country): <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Eugene P. Keefe</u>		14. MOTHER'S MAIDEN NAME: <u>Nester Anne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Bessie N. Keefe, 7305 Holly Ave. J.P. Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.0</u>		<u>15 min.</u>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) <u>Acute myocardial Failure</u> DUE TO (B) <u>Arteriosclerotic Heart Disease</u> DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 1955, to <u>April</u> , 1955, that I last saw the deceased alive on <u>April 7</u> , 1955, and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Russell B. Arnold</u>		DATE SIGNED <u>4 May 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial - St. Mary's</u>		DATE THEREOF <u>May 6 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>St. Mary's, Georgia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 4 1955</u>		24. FUNERAL DIRECTOR <u>J. Arthur Walker, 250 Carroll St. N.W. W.C.</u>	

RECEIVED

MAY 6 1955

BUREAU V. S.

M

4832

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04814

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 216

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN KensingtonLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS4101 Knowles Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN KensingtonSTREET ADDRESS 4101 Knowles Ave. (If rural, give location)3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HERBERT NEWTON KEENE, JR.4. DATE
OF
DEATH

(Month)

(Day)

(Year)

May 19, 19 55

5. SEX:

Male6. COLOR OR
RACE:White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)Married

8. DATE OF BIRTH:

Sept. 16,

9. AGE Last birthday:

70 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired)Ret. Architect Self Emp.10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Washington, D.C.12. CITIZEN OF WHAT
COUNTRY?US

13. FATHER'S NAME:

Herbert N. Keene, Sr.

14. MOTHER'S MAIDEN NAME:

Laura Gibson15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)No

16. SOCIAL SECURITY No.:

None17. INFORMANT & ADDRESS: 10414 Parkwood Dr.
Kensington, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

(b).....

Diseases or conditions, if any,
giving rise to the above cause DUE TO
stating underlying cause last

(c).....

INTERVAL BETWEEN
ONSET AND DEATHSudden
deathII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF
street, office bldg., etc.,
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF
INJURY

M.

21e. INJURY OCCURRED
While at Not while
work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Frank J. Brosehart

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D. ASSISTANT MEDICAL EXAM. ☒5-19-5523. BURIAL, CREMATION,
REMOVAL (Specify):Burial

DATE THEREOF

5-21-55

NAME OF CEMETERY OR CREMATORY

Glenwood

LOCATION (City, town, or county)

Washington

(State)

D.C.DATE REC'D BY LOCAL
REG.5/21/55

REGISTRAR'S SIGNATURE

Bessie M. Thompson

24. FUNERAL DIRECTOR

Robert A. Campbell

ADDRESS

Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 24 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04815

4762

CERTIFICATE OF DEATH

Reg. Dist. No. 22.3

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Mash, D.C.</i>		COUNTY <i>47X-3</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
17 TOWN <i>Takoma Park</i>		5 days		<i>Washington, D.C.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
75 <i>Washington Sanitarium</i>				<i>211 Webster Street.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Edward Carlton King</i>				<i>May 27 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<i>Male</i>	<i>White</i>	<i>Widowed</i>	<i>4-25-02</i>	<i>53 yrs.</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>Cab Driver</i>						<i>Maryland</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Edward C. King</i>				<i>Nonie Lydard</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<i>No</i>						<i>Admission Record Mash. Sanitarium</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Acute Coronary Occlusion</i>						<i>1 hour</i>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Atherosclerosis</i>							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>5/9/55</i>		<i>Segmental occlusion of left iliac artery</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <i>5/8/55</i> , 19 <i>55</i> , to <i>5/27</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5/27</i> , 19 <i>55</i> , and that death occurred at <i>9:45 AM</i> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>Lytle Adellum</i>		<i>M.D. 8700 Colanville Rd Silver Spring</i>		<i>5/27/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 30, 1955</i>		<i>Salem Cedar Grove</i>		<i>Cedar Grove Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>May 27-1955</i>		<i>J. Wilma Reed</i>		<i>Roy W. Barber</i>		<i>Laytonville Md.</i>	

RECEIVED

MAY 31 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04816

4763

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>TAKOMA PARK</u>		1 YR		OR TOWN <u>BALTIMORE MD. 3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>7311- MAPLE AVE</u>				<u>3705 TOWANDA AVE</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>FANNIE LEAH KOMINETSKY</u>				OF DEATH: <u>MAY 21 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>		<u>FEB 10, 1883</u>	<u>72</u> yrs.	Months	Days	Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>				<u>RUSSIA</u>		<u>RUSSIA</u> ✓	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>HYMAN BUDOWSKY</u>				<u>MINNIE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS:			
<u>NO</u>				<u>CLARA SCHWARTZ 7311 MAPLE AVE F. P. MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>442X</u>							
IMMEDIATE CAUSE (A)						<u>Pulmonary edema</u>	
ANTECEDENT CAUSE (S)						<u>10 min.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>Arteriosclerotic cardiovascular disease</u>	
						<u>1 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 2, 1954</u> , to <u>May 21, 1955</u> , that I last saw the deceased alive on <u>May 21, 1955</u> , and that death occurred at <u>2:45 P</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Simon C. Weiner</u>		<u>100 Longfellow St NW</u>		<u>May 21, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-22-1955</u>		<u>MT. CARMEL</u>		<u>BALTO. MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>MAY 22 1955</u>		<u>Frank Williams</u>		<u>Frank Leurs Inc - 2100 Eutan PL</u>			

RECEIVED

MAY 24 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4833

CERTIFICATE OF DEATH

Reg. Dist. No.

04817

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Green Acres</u>		<u>17 yrs</u>		TOWN <u>Green Acres</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>4922 Redford Rd</u>				<u>4922 Redford Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Wilson Norris Krahnke</u>				<u>5 14 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct 14, 1906</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Potomac Elec. Power Co</u>		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Ferdinand H. Krahnke</u>				14. MOTHER'S MAIDEN NAME: <u>Clara Etta Reynolds</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-03-1533</u>		17. INFORMANT & ADDRESS: <u>4922 Redford Rd Catharine Krahnke Green Acres Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of large & small intestine</u>							<u>2 1/2 mos.</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Mar. 1 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Inoperable carcinoma of large & small intestine</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					
22. I hereby certify that I attended the deceased from <u>Jan. 1945</u> , to <u>May 14, 1955</u> , that I last saw the deceased alive on <u>May 13, 1955</u> , and that death occurred at <u>3:15 P M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Richard V. Matthews</u>		ADDRESS <u>M. D. 4707 Corn. Ave. NW.</u>		DATE SIGNED <u>5/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Partial - Transit</u>		DATE THEREOF <u>5-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/17/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>2901 14th St. S.W. S. H. Hicks Co. Washington D. C.</u>			

BUREAU V. 1

MAY 18 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4834 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04818
 Items 8,9: film G181 5-23-55 **CERTIFICATE OF DEATH** Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring 56			
X TOWN Bethesda Rural		1 mo 4 days		STREET ADDRESS (If rural give location) 2406 Dexter Avenue			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital							
3. NAME OF DECEASED: (First) Lynnwood (Middle) Agustin (Last) KUHN				4. DATE (Month) (Day) (Year) OF DEATH: May 18 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 11-15-22	9. AGE last birthday: 39 yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior Decorator			10B. KIND OF BUSINESS OR INDUSTRY: Self Employed		11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John B. KUHN				14. MOTHER'S MAIDEN NAME: Grace GRUNINGER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS: Wife Mrs. Ruth E. KUHN Same as above	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Malignant melanoma, multiple metastases						7 months	
ANTECEDENT CAUSE (S) DUE TO (B) Malignant melanoma, left shoulder						3 years.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 190X		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 14 Apr , 19 55 , to 18 May , 19 55 , that I last saw the deceased 18 May , 19 55 , and that death occurred at 1:55A M, from the causes and on the date stated above.							
E. P. THELEN LCDR MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland				ADDRESS DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 20 May 1955		NAME OF CEMETERY OR CREMATORY Parklawn Cemetery Rockville Pike, Rockville, Maryland		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR 18 May 1955		REGISTRAR'S SIGNATURE Mary E. Carrelly		24. FUNERAL DIRECTOR Chevy Chase Funeral Home		ADDRESS 5103 Wisconsin Ave., N.W. Washington, D.C.	

BUREAU V. S.

MAY 23 1955

RECEIVED

4835

CERTIFICATE OF DEATH

Reg. Dist. No. 217...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Olney</u>		12hrs. 40 min.		TOWN <u>Silver Spring</u> 56			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		The Montgomery County General Hospital, Inc.		STREET ADDRESS (If rural give location)			
23				R#2 Peach Orchard Road			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Joseph Ernest Leizear</u>				OF DEATH: <u>May 8 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
male	white	married	August 3/1873	81 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
painter		Own business		Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joseph Leizear</u>				<u>Sarah Catherine Colbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
		579-09-0351		Hospital Records			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE						25 days	
(A) <u>Secondary Anemia</u>							
ANTECEDENT CAUSE (S)						1 year	
(B) <u>Carcinoma Bladder</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>L</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0				L			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>5/6</u> , 19 <u>55</u> , to <u>5/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/7</u> , 19 <u>55</u> and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>JMB-1</u>		M. D. <u>Sandy Sp</u>		DATE SIGNED <u>5/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
Burial		5/10/55		Union Cemetery		Burtonsville, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5-12-55		<u>Arthur B. Lawler</u>		<u>Warner E. Humphrey</u>		8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 17 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04820

4836

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>			
56 TOWN <u>Silver Spring</u>		18 yrs		56 STREET ADDRESS (If rural give location) <u>8606 Cedar Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8606 Cedar Street</u>				1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Alice Mary Leonard				May 21 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
Female	White	Widowed	9/11/70	84 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own home		Canada		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William B. Boler				Ellen B. Grogan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
4 no		none		Mrs. Margaret M. Tuhy, 8606 Cedar Street Silver Spring, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>						6-8 yrs	
ANTECEDENT CAUSE (S) (B) <u>Hypertension</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Atherosclerosis</u>						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>						?	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from 1940 to 21 May 1955 that I last saw the deceased alive on 21 May 1955, and that death occurred at 3 P M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>William D. And</u>		<u>Silver Spring</u>		<u>5/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Trans. & Burial		5/24/55		St. Francis Cemetery		Oakland, Massachusetts	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
May 27, 1955		<u>Frances Potter</u>		<u>Warren L. Humphrey</u>		8434 Ga. Ave. Silver Spring, Md.	

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4837 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18.

04821

Item 18 Film G182 5-27-55 **CERTIFICATE OF DEATH**

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Tt Montgomery</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Tt Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Springs, 56</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural, give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				803 Hale Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Miss <u>Illing</u> <u>P. Loeschke</u>				OF DEATH: <u>May 10 1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>July 9, 1900</u>	
				9. AGE last birthday <u>54</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Worker, Jr. High School</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>Paul Loeschke</u>				14. MOTHER'S MAIDEN NAME: <u>Wilhelmina Booker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-32-2458</u>		17. INFORMANT & ADDRESS: <u>625 Dennison St. Elmer F. Reddick, Baltimore, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
223X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>				<u>? hours</u>			
ANTECEDENT CAUSE (S) (B) <u>Infarction, Pons (believed to be a Meningioma)</u>				<u>2 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Craniotomy for Brain Tumor</u>				<u>4 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Atelectasis, tracheal obstruction</u>				<u>? hours</u>			
19A. DATE OF OPERATION: <u>May 6, 1955</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 24</u> , 19 <u>53</u> to <u>10 May</u> , 19 <u>55</u> that I last saw the deceased alive on <u>10 May</u> , 19 <u>55</u> , and that death occurred at <u>4.17 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ernest E. Harmon</u>				ADDRESS <u>9301 Coleridge Rd Silver Spring Md</u>		DATE SIGNED <u>19 May 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/17/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

RECEIVED

MAY 19 1955

BUREAU V. 1

4764

CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>15 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park</u>		17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 Lee Avenue</u>				STREET ADDRESS (If rural, give location) <u>8 Lee Avenue</u>		1	
3. NAME OF DECEASED: (First) <u>Elizabeth</u>		(Middle) <u>Mac</u>		(Last) <u>Innis</u>		4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug. 19 1879</u>		9. AGE last birthday: <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Nova Scotia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Peter C. MacInnis</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Gillis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Frank R. MacInnis, 8 Lee Ave. Takoma Park, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.0 Immediate cause			(a) <u>Inanition, decubitus ulcers</u>			<u>2 months</u>	
Antecedent cause(s)			(b) <u>Arteriosclerotic heart disease</u>			<u>3 yrs</u>	
Diseases or conditions, if any giving rise to the above cause stating underlying cause last			(c) <u>Generalized arteriosclerosis</u>			<u>1/3 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS: <u>a. Rheumatoid arthritis, severe</u>							<u>3 yrs.</u>
<u>b. Senility</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/27/1952</u> , to <u>5/13/1955</u> , that I last saw the deceased alive on <u>May 3, 1955</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wallace M. Mook</u>				(DEGREE OR TITLE) <u>D.</u>		ADDRESS <u>7701 Carroll Ave. Takoma Park, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>May 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		LOCATION (City, town, or county) <u>St. Mary's</u>	
DATE REC'D BY LOCAL REGISTRY <u>May 13 1955</u>		REGISTRAR'S SIGNATURE <u>J. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Walter D. H. H.</u>		ADDRESS <u>Takoma Park 12, D.C.</u>	

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MAY 16 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film 181 5-19-55 et

04823

4838

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Bethesda Rural		2 Days		OR TOWN Bethesda X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 8300 Wisconsin Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Victor Wayne MARSH				DEATH: May 2 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Caucasian	Single	11-30-54	yrs. 5	Months 2	Days 2	Hours 5 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant				10B. KIND OF BUSINESS OR INDUSTRY: Not Applicable		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME: Walter J. MARSH				14. MOTHER'S MAIDEN NAME: LINTHICUM, Suzanne			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY No. None		17. INFORMANT & ADDRESS: Walter J. MARSH (Father) Same as above	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pneumonia, lobar, left lung						48 hrs	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 30 April 1955 to 2 May , 1955 that I last saw the deceased live on 2 May , 1955, and that death occurred at 10:20 AM , from the causes and on the date stated above.							
SIGNATURE D. J. PASCOE LT, MC, USN				ADDRESS M. D USNH, NNMC, Bethesda, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-6-54		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Mary E. Casella		24. FUNERAL DIRECTOR B. A. Pumphrey Funeral Home		ADDRESS 8300 Wisconsin Avenue, Bethesda, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4839

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04824

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>1 hr.</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Barnesville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Caroline</u> (Middle) <u>Marie</u> (Last) <u>Mayhew</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>4/18/49</u>	
9. AGE last birthday: <u>6</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>School - Student</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Francis Mayhew</u>				14. MOTHER'S MAIDEN NAME: <u>Mattie Ward</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Francis Mayhew - Barnesville, Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
(a) <u>Shock + pleural & abdominal hemorrhage</u>				<u>1 1/2 hrs</u>			
Immediate cause DUE TO							
(b) <u>Ruptures of left lung, spleen both kidneys</u>				<u>1 1/2 hrs</u>			
Antecedent cause(s) DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Auto Accident</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>2</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Highway</u>		21c. (City or town) <u>Barnesville</u> (County) <u>Montg</u> (State) <u>md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>crossed highway in front of approaching car</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschaut</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-6-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Park</u>		LOCATION (City, town, or county) <u>Gaithersburg Md</u> (State)	
DATE REC'D BY LOCAL REG. <u>5/10/55</u>		REGISTRAR'S SIGNATURE <u>Beau M. Thompson</u>		24. FUNERAL DIRECTOR <u>William B. Hiltey</u> ADDRESS <u>Barnesville, Md</u>			

RECEIVED
MAY 12 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04825

4840

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Pennsylvania</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>23 days</u>		OR TOWN <u>Shippensburg</u> <u>75x-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location)			
50 <u>Natl. Institutes of Health</u>				<u>R.D. #3</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Ann</u> <u>M.</u> <u>McCormick</u>				OF DEATH: <u>May</u> <u>20</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>Single</u>	<u>19 June 1950</u>	<u>4</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John P. McCormick</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Kane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
754.4 IMMEDIATE CAUSE (A) <u>Chronic heart failure</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Congenital cyanotic heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Pulmonary valve stenosis and patent foramen ovale</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Asplenia</u>							
19A. DATE OF OPERATION: <u>May 20, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Pulmonary stenosis</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21C. WHERE DID (City or town) INJURY OCCUR? <u>--</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u> <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>April 27, 1955</u> to <u>May 20, 1955</u> , that I last saw the deceased alive on <u>May 20, 1955</u> , and that death occurred at <u>11:00 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert A. Cumfrey</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>5/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>5-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Pittston</u>		LOCATION (City, town, or county) (State) <u>Pittston, Pa.</u> <u>Penna</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Cumfrey</u>		ADDRESS <u>Bethesda, Md.</u>	

BUREAU V. S.

MAY 26 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4765
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04826
 Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN <u>17</u>	
TOWN <u>Takoma Park</u>		<u>D.O.A.</u>		TOWN <u>Takoma Park</u>		<u>17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. + Hosp.</u>				STREET ADDRESS (If rural, give location) <u>7310 Willow Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles Leonard McCormick</u>				<u>May 31 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>April 18, 1955</u>	9. AGE last birthday: <u>6 weeks</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Takoma Park, Md.</u>		<u>Amer</u>	
13. FATHER'S NAME: <u>Mr Charles J McCormick</u>				14. MOTHER'S MAIDEN NAME: <u>Corinne Ruth Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)							

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						?	
491X Immediate cause (a) <u>Broncho-pneumonia</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Frank J. Brosehart</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-31-55</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>6-2-55</u>		<u>Hillcrest Burial Park</u>		<u>Cumberland, Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>May 31 1955</u>		<u>F. Wilson Doherty</u>		<u>Robert A. Humphrey Bethesda, Md.</u>			

2045243573

RECEIVED

JUN 1 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04827

4841

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hyattsville</u> <u>1615-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>		STREET ADDRESS (If rural give location) <u>5902 36th Ave.</u>					
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Arthur</u> <u>Leo</u> <u>McWilliamson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>9</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5/26/47</u>	9. AGE last birthday <u>7</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Ernest McWilliamson</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Goode</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) <u>--</u> (If Yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE		(A) <u>Cerebral hemorrhage, base of brain</u>					
ANTECEDENT CAUSE (S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Pulmonary edema</u>					
		DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypersplenism and liver necrosis</u>							
19A. DATE OF OPERATION: <u>--</u>		19B. MAJOR FINDINGS OF OPERATION: <u>--</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21C. WHERE DID (City or town) INJURY OCCUR? <u>--</u>		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>May 2</u> , 1955, to <u>May 9</u> , 1955, that I last saw the deceased alive on <u>May 9 1955</u> , and that death occurred at <u>8:30aM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Darroff</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>5/9/55</u>		M.D. <u>Natl. Institutes of Health</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>5-12-55</u>		DATE THEREOF <u>5-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem. Wash. D.C.</u>		LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>1st Funeral Home</u>		ADDRESS <u>300 2nd St. N.E. Wash. D.C.</u>	

RECEIVED

MAY 11 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4766
CERTIFICATE OF DEATH

04828

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	LENGTH OF STAY (in this place) 6 days	CITY (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 75 Washington Sanitarium & Hospital		STREET ADDRESS (If rural give location) 808 Houston Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last) French Sterling Meadows		4. DATE (Month) (Day) (Year) OF DEATH: 5-22-1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: 9-24-89
9. AGE last birthday: 65 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired		10B. KIND OF BUSINESS OR INDUSTRY: ?	
11. BIRTHPLACE (State or foreign country): Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Sterling Meadows		14. MOTHER'S MAIDEN NAME: Virginia Mayfield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Hospital Record			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Acute coronary artery thrombosis		9 days	
ANTECEDENT CAUSE (B) Generalized arteriosclerosis		-	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Diabetes mellitus		-	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis Obliteration of lower extremities			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 13, 1955 , to May 22, 1955 , that I last saw the deceased alive on May 22, 1955 , and that death occurred at 5:30 M, from the causes and on the date stated above.			
SIGNATURE Sydney Leventhal, M.D.		ADDRESS Silver Spring Md	
DATE SIGNED May 22 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 5/25/55	
NAME OF CEMETERY OR CREMATORY St. Lincoln Cem.		LOCATION (City, town, or county) (State) Prince Georges Ind.	
DATE REC'D BY LOCAL REGISTRAR May 22 1955		REGISTRAR'S SIGNATURE J. William Dodd	
24. FUNERAL DIRECTOR		ADDRESS 8732	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04829

4767

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> OR TOWN <u>Takoma Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington San. & Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> OR TOWN <u>Bethesda</u> STREET ADDRESS (If rural give location) <u>4807 Hampden Lane</u>	
3. NAME OF DECEASED: (Type or Print) <u>Flavia</u> (First) <u>Ann</u> (Middle) <u>Moise</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>29</u> <u>1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white american</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>May-12-1890</u>
9. AGE last birthday <u>65</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	11. CITIZEN OF WHAT COUNTRY? <u>American</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <u>Charles H. Hungerford</u>		14. MOTHER'S MAIDEN NAME: <u>AMy J. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Wash. San. & Hosp. records</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Malignant lymphoma</u> ANTECEDENT CAUSE (S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/27/1955</u> , to <u>5/29/1955</u> , that I last saw the deceased alive on <u>5/27/1955</u> , and that death occurred at <u>7A</u> M; from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M. D. <u>500 Underwood St N.W. 5/29/55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-1-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Congressional Ave NW Wash D.C.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>May-29-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>R.C. Pumphrey</u>		ADDRESS <u>Bethesda</u>	

UNITED STATES DEPARTMENT OF HEALTH

BUREAU V. 1

JUN 1 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04830

4842

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellen Echo</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>104-Cassarville</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>Leddie</u> (Middle) <u>Thomas</u> (Last) <u>Money</u>				DATE: <u>May</u> <u>29</u> <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>May 2, 1894</u>	
				9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Machinist</u>		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>Thomas Randolph Money</u>				14. MOTHER'S MAIDEN NAME: <u>Lenora Kettner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>316-15th f.e.</u>		17. INFORMANT & ADDRESS: <u>Miss Lois Money Wash. D.C.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						37 hours	
ANTECEDENT CAUSE (S) DUE TO (B) <u>cerebral arteriosclerosis</u>						undetermined	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-27</u> , 19 <u>55</u> , to <u>5-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-29</u> , 19 <u>55</u> and that death occurred at <u>1:00</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>John Lewis, M.D.</u>		ADDRESS <u>4031 Parkview Drive Silver Spring, Md.</u>		DATE SIGNED <u>5-29-55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/1/55</u>		NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/1/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u>		ADDRESS <u>1400 Chapin St. Wash. D.C.</u>	

RECEIVED

JUN 6 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4843

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04831

Item 7, Film G181, 5/11/55 10y

CERTIFICATE OF DEATH

Reg. Dist. No. 276

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Glen Echo</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (if rural give location) <u>104 Vassar Circle</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Mrs. Ella R. Titoney</u>				<u>May 3, 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1/19/92</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington DC,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>E. Klein</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Cedric T. Money</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE		(A) <u>Cardiovascular Incident</u>		INTERVAL BETWEEN ONSET AND DEATH		<u>4 days</u>	
ANTECEDENT CAUSE (B)		(B) <u>Hypertension</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/30</u> , 19 <u>55</u> , to <u>5/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/2</u> , 19 <u>55</u> , and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. L. Marks M.D.</u>		ADDRESS <u>M. D. 6306 Wisconsin Ave N.W., Wash. D.C.</u>		DATE SIGNED <u>5/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		LOCATION (City, town, of county) (State) <u>Suitland Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>W. W. Chambers Co</u>		ADDRESS <u>3072 M. St. N.W. Wash. D.C.</u>	

MAY 9 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04832

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>SAME</u> COUNTY <u>Rockville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>13205 Ardennes Ave</u>		STREET ADDRESS (If rural, give location) <u>13205 Ardennes Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna Justine Mooney</u>		4. DATE OF DEATH <u>May 20, 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 17, 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>93</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>BERWICK PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIMON Sittler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth De Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Thelma Mooney</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cardio-respiratory Failure</u>		<u>30'</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>myocardial infarction</u>		<u>6 mos</u>
	(c) <u>coronary arteriosclerosis</u>		<u>Indefinite</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9/2/1954, to 5/20/1955, that I last saw the deceased alive on 5/20/1955, and that death occurred at 1:55 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-22-55</u>	<u>Pine Grove Cemetery</u>	<u>BERWICK PA.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5-22-55</u>	<u>Samuel H. Bragdon</u>	<u>W.W. Chambers</u>	<u>3072 M. St. NW.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 25 1935

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#8. Film 181 5/17/55 1st

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

048336

4844

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>Virginia</u> COUNTY <u>Norfolk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Norfolk</u>		STREET ADDRESS (If rural give location) <u>210 East Randall Ave.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>49 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Norfolk</u>		STREET ADDRESS (If rural give location) <u>210 East Randall Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>210 East Randall Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John Edward Moran</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>5 - 3 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>11-4-88</u>	
9. AGE last birthday: <u>66</u> yrs.		10. AGE last birthday: <u>66</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired printer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired printer</u>			
13. FATHER'S NAME: <u>John Moran</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Clements</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Adelaide P. Moran - wife</u>			
17. INFORMANT & ADDRESS: <u>210 East Randall Ave. Norfolk, Va.</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>443X</u> <u>Cordiac Decompensation</u>							
ANTECEDENT CAUSE (S) <u>Hypertensive Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Old focal encephalomalacia due to thrombosis</u>							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-1-55</u> , 19....., to <u>5-3-55</u> , 19....., that I last saw the deceased alive on <u>5-3-55</u> , 19....., and that death occurred at <u>7:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert J. Philadelpo</u>				ADDRESS <u>Kennington</u>		DATE SIGNED <u>5-4-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town or county) (State) <u>Colmar Manor Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 9 1955</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>F. Gasch Sons</u>		ADDRESS <u>Hyattonville Md.</u>	

RECEIVED

MAY 11 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04834

4845

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Cedar Grove</u>			
TOWN <u>Olney</u>		<u>2 days</u>		STREET ADDRESS (If rural give location) <u>R.F.D. #1 Germantown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County Gen'l Hosp.</u>							
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>Samuel</u>		<u>Eugene</u>		<u>Mullinix</u>			
4. DATE (Month) (Day) (Year)		OF DEATH: <u>5/8/55</u>		19			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>1/26/15</u>	<u>40</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Saw Mill & Threshing</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Samuel E. Mullinix</u>				14. MOTHER'S MAIDEN NAME: <u>Elsie Moxley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-26-9128</u>		17. INFORMANT & ADDRESS: <u>Hospital records</u>			
		(If Yes, give war or dates of service)					
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Gastro-intestinal hemorrhage</u>							<u>60 hours</u>
ANTECEDENT CAUSE (B) <u>Metastatic melanoma of liver</u>							<u>2 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Melanoma (malignant) retina left eye</u>							<u>2½-3 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/10/</u> , 1955, to <u>5/8</u> , 1955, that I last saw the deceased alive on <u>May 8</u> , 1955, and that death occurred at <u>5:07PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>B. J. Moxley</u>				ADDRESS <u>M. D. Damascus, Md.</u>		DATE SIGNED <u>May 8, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 11, 1955</u>		<u>Salem</u>		<u>Cedar Grove, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-9-55</u>		<u>B. J. Moxley</u>		<u>Olin L. Molesworth</u>		<u>Damascus, Md.</u>	

RECEIVED
MAY 13 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04835

4846

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>				TOWN <u>Bethesda</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7108 Exfair Rd</u>				STREET ADDRESS (If rural give location) <u>7108 Exfair Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Peter T. Murphy</u>				OF DEATH: <u>5</u> <u>31</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>April 17, 1865</u>	<u>90</u> yrs.	<u>1</u> Months	<u>14</u> Days	<u>14</u> Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>U.S. Gov.</u>		<u>Ireland</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Terence Murphy</u>				<u>Ellen Traynor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>no</u> (If Yes, give war or dates of service)		<u>None</u>		<u>Margaret Collins</u> <u>7108 Exfair Rd. Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arterio sclerotic Heart Disease</u>						<u>6 yrs</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 20, 1953</u> , to <u>May 31, 1953</u> , that I last saw the deceased alive on <u>May 31, 1953</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>P. J. Brennan</u>		M. D. <u>Bethesda</u>		DATE SIGNED <u>5-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-2-1955</u>		<u>Ft. Lincoln Cem.</u>		<u>Prince George Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6/1/55</u>		<u>Bessie M. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

BUREAU V. S.

JUN 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04836

4768

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>21 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>				STREET ADDRESS (If rural give location) <u>715 Ritchie Ave.</u>		<u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Julia Margaret Nasella</u>				<u>5-24-1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>9-11-80</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hsuf.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Own home</u>		11. BIRTHPLACE (State or foreign country): <u>Ireland</u>	
13. FATHER'S NAME: <u>JAMES DUGAN</u>				14. MOTHER'S MAIDEN NAME: <u>Hanara Doyle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Hospital Record</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary & Cerebral Infarction</u>						<u>3 wks</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Pulmonary Thromboses</u>						<u>3 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Rt. Posterior Cerebral artery "</u>						<u>3 wks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>						<u>3 wks</u>	
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15, 1955</u> , to <u>May 24, 1955</u> , that I last saw the deceased alive on <u>May 24, 1955</u> , and that death occurred at <u>4:40 P M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel J. Dugan</u>				ADDRESS <u>not known Md</u> DATE SIGNED <u>5/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 26 1955</u>		REGISTRAR'S SIGNATURE <u>William D. Dodel</u>		24. FUNERAL DIRECTOR <u>Wm. W. C. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4778

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

014837
No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>P. G.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>26 Rockville</u>		LENGTH OF STAY (in this place) <u>3 mo</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Mt. Rainier</u> <u>16-16-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>702 Beall Ave</u>				STREET ADDRESS (If rural, give location) <u>3407 Newton St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Eleanor Gallagher Nicholson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 27 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>8-2-'99</u>	9. AGE last birthday: <u>57</u> yrs. <u>9</u> Months <u>25</u> Days		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Medical nursing</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Naomi Nicholson - Same as above 1</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Coronary occlusion</u>		DUE TO		<u>Sudden death</u>	
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>		DUE TO			
(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. <u> </u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.					
SIGNATURE <u>James J. Burckhart</u>		M. D. <u>Robert A. Humphrey</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5-31-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	
LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>		24. GENERAL DIRECTOR ADDRESS <u>Bethesda, Md.</u>			
DATE REC'D BY LOCAL REG. <u>5/31/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Grayson</u>		25. GENERAL DIRECTOR SIGNATURE <u>Robert A. Humphrey</u>	

BUREAU V. S.

JUN 4 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4769

CERTIFICATE OF DEATH

Reg. Dist. No. 048383

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>Takoma Park, Md</u>		<u>3 days</u>		TOWN <u>Silver Spring</u> <u>56</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>25 Washington San & Hospital</u>				<u>813 Bonifant ST.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>William Perry Nixon</u>				<u>May 27 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>3-26-95</u>	<u>60 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Loan Spec. Dept. Agric.</u>				<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John A. Nixon</u>				<u>Mary Ann Perry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes, W.W.I.</u>						<u>Mrs. Thelma Cecile Nixon - Silver Spring</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Anemia</u>						<u>3 month</u>	
ANTECEDENT CAUSE (S) <u>Pulmonary Emboli</u>						<u>2 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1955, to <u>May 27</u> , 1955, that I last saw the deceased alive on <u>May 26</u> , 1955, and that death occurred at <u>1:30A M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>10760 adrop md.</u>		<u>M. D. 837 Boulevard Silver Spring Md</u>		<u>5/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-29-55</u>		<u>St. Marks</u>		<u>Petersville Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6/2/55</u>		<u>Laurel Dr. Kraybill</u>		<u>C. H. Feltz & Bro</u>		<u>Baltimore Md</u>	

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

1955

Blank form area for death certificate details, including fields for name, date, and cause of death.

BUREAU V. S.

JUN 3 1955

RECEIVED

RECEIVED

04839

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

4847

1. PLACE OF DEATH- COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>815 Richmond Avenue</u>		STREET ADDRESS <u>815 Richmond Avenue</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sallie</u>	(Middle) <u>Ann</u>	(Last) <u>Palmer</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>25</u>	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 16, 1872</u>
9. AGE last birthday <u>83</u> yrs.		If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton A. Morris</u>		14. MOTHER'S MAIDEN NAME <u>Eliza A. Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Barber C. Palmer, Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Pneumonitis - Pulmonary Edema</u>			<u>15 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Chronic myocarditis - hypertension - cardiovascular-renal disease.</u>			<u>15 years</u>
(c) <u> </u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct.</u> , 19 <u>33</u> , to <u>May 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 25</u> , 19 <u>55</u> , and that death occurred at <u>12:15 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>E. A. Krause, M.D.</u>		ADDRESS <u>3805 McKinley St. N.W., Wash. 15, D.C.</u> DATE SIGNED <u>May 25, 1955.</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/28/55</u>	NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>	LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>
DATE REC'D BY LOCAL REG. <u>5-31-55</u>	REGISTRAR'S SIGNATURE <u>James C. Potter</u>	24. FUNERAL DIRECTOR ADDRESS <u>Wm. E. Pamphrey Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

JUN 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

04840

1. PLACE OF DEATH- COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u> <u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery Hills Texaco Service Station</u>				STREET ADDRESS (If rural, give location) <u>9402 Warren Street</u> <u>1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Fred</u>	(Middle) <u>Daniel</u>	(Last) <u>Pence</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>19</u> (Year) <u>19 55</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 9, 1898</u>	9. AGE last birthday <u>56</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Owner of a Filling Station</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Edinburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph Pence</u>			14. MOTHER'S MAIDEN NAME <u>Lilli Summers</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>Mr. Fred J. Pence, 9402 Warren St.</u>	
18. MEDICAL CERTIFICATION <u>Silver Spring, Md.</u>					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u>				<u>Sudden death</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE <u>Frank J. Bruchart M.D.</u>		(Degree or title)		DATE SIGNED <u>5-19-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Trans. & Burial</u>		DATE THEREOF <u>5/23/55</u>		LOCATION (City, town, or county) (State) <u>Hawkinstown Cemetery</u> <u>Shenandoah County, Virginia</u>	
DATE REC'D BY LOCAL REG. <u>May 23/55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>	

BUREAU V. S.

MAY 26 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04841

4849

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DAMASCUS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - New Windsor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>10X-R</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>P</u> (Last) <u>POOLE</u>	4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-23-1876</u>
9. AGE last birthday <u>78</u> yrs.		10. AGE last birthday If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John T. Poole</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CARVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Sterling Black, Damascus, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422 Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>5 hours</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic cardiovascular disease</u>		<u>10 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 9</u> , 19 <u>55</u> , to <u>May 12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 15</u> , 19 <u>55</u> , and that death occurred at <u>4:30</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>James J. Kern</u>		ADDRESS <u>74-N Damascus Md.</u>	
DATE SIGNED <u>5/12/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
<u>BURIAL</u>		<u>5-15-1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>WINGANORE</u>		<u>Frederick Co. Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
<u>May 12, 1955</u>		<u>Della A. Burdette</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>L. D. Wally</u>		<u>Winfield Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 18 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04842

4850

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Bethesda Rural</u>		<u>3 days</u>		<u>Arlington</u> <u>83 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>2510 16th Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Janet Cook PORTER</u>				<u>May 1 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>S single</u>	<u>1-13-53</u>	<u>2 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>California</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Robert C. PORTER</u>				<u>Sylvia CONANT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>-</u>		<u>Father: Robert C. PORTER 2510 16th N. Arlington, Virginia</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) DUE TO <u>Cerebral thromboembolism</u>						<u>1 day</u>	
ANTECEDENT CAUSE (B) DUE TO <u>Subacute bacterial Endocarditis</u>						<u>2 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Congenital Heart Disease</u>						<u>27 mo</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>2</u>							
20. AUTOPSY?							
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>28 Apr.</u> , 1955, to <u>1 May</u> , 1955, that I last saw the deceased alive on <u>1 May</u> , 1955, and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>M. S. ALLEN LT</u>		<u>MC USN U.S. Naval Hospital, NNMC, Bethesda, Md.</u>		<u>1 May 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5 May 1955</u>		<u>Columbia Cemetery</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-1-55</u>		<u>Mary E. Parrelly</u>		<u>IVES FUNERAL HOME</u>		<u>2847 Wilson Blvd. Arlington, Virginia</u>	

BUREAU V. S.

MAY 9 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4851

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04843

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Item 7, Film G181, 5/11/55

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Springs</u>	<u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>11814 Kluggins Ln.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE (Month) (Day) (Year)		
<u>Mrs. Edith S. Rice</u>	<u>May 6 1955</u>		
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>4/13/92</u>
9. AGE last birthday <u>63</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>
			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME: <u>Woodruff</u>		14. MOTHER'S MAIDEN NAME: <u>Carter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		15. SOCIAL SECURITY NO.	
<u>9</u>			
16. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Typhemia</u>			
ANTECEDENT CAUSE (S) DUE TO <u>cerebral hemorrhage</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>total hysterectomy for bleeding</u>			
(C) <u>carcinoma of cervix</u>			<u>5 April 29/55</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>14/29/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>bleeding uterus</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3-15</u> , 19 <u>55</u> , to <u>5-6</u> /55, that I last saw the deceased alive on <u>5-6</u> , 19 <u>55</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
		<u>John C. Ralston M.D.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>May 9, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>
DATE REC'D BY LOCAL REGISTRAR <u>5/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>The S. N. Harris Co.</u>
		ADDRESS <u>2901 14th St. Washington, D.C.</u>	

RECEIVED

MAY 9 1955

BUREAU V. S.

4852

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>GERMANTOWN, MD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MT. RAINIER</u> 16-16-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>INSTITUTION MARYLANDER</u>		STREET ADDRESS (If rural give location) <u>4226 31ST ST.</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>HELEN</u> <u>RICHARDS</u>		<u>MAY</u> <u>8</u> <u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>FEB 13, 1865</u>
9. AGE last birthday <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE IN OWN HOME</u>	
11. BIRTHPLACE (State or foreign country): <u>CLARKSBURG, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>G. W. MURPHY</u>		14. MOTHER'S MAIDEN NAME: <u>JULIA SHRIVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>HOME RECORDS</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4221 IMMEDIATE CAUSE		(A) <u>Intermittent cardiovascular disease</u> 5 years	
ANTECEDENT CAUSE (S)		(B) _____	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Feb 9</u> , 1955, to <u>May 8</u> , 1955, that I last saw the deceased alive on <u>May 3</u> , 1955, and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>James P. Keen</u>		DATE SIGNED <u>May 8, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<u>REMOVAL</u>		<u>WALLEY'S FUNERAL HOME</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 12/55</u>		ADDRESS <u>3200 R.I. AVE</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4853

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04845

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Olney</u>		<u>1 day</u>		<u>Laytonsville</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>73</u> <u>Montgomery County General Hospital, Inc</u>				<u>/</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
(Type or Print)		<u>Edward Francis Riordan</u>		OF DEATH: <u>May</u> <u>13</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>7/19/1866</u>	<u>88</u> yrs.	Months	Days	Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Blacksmith</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Daniel Riordan</u>				<u>Catherine Costello</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>9</u>				<u>Hospital Record</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE						<u>420.0</u>	
(A) DUE TO <u>Acute Congestive Heart Failure</u>						<u>9 hours</u>	
ANTECEDENT CAUSE (S)						<u>Not known</u>	
(B) DUE TO <u>Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
<input type="checkbox"/>		<u>Home</u>		<u>Laytonsville Mont. Md.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>May 11 55 2:00 PM</u>				<u>Fell while reaching for regt. att.</u>			
22. I hereby certify that I attended the deceased from <u>May 11, 1955</u> , to <u>May 13, 1955</u> , that I last saw the deceased alive on <u>May 13, 1955</u> , and that death occurred at <u>6:18 PM</u> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<u>Jack Schumacher</u>		<u>Dr. Schumacher</u>		<u>Southview, Md.</u>		<u>May 14, 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 16 1955</u>		<u>St. Peter's Cemetery</u>		<u>Laytonsville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-15-55</u>		<u>Arthur B. Fowler</u>		<u>W. Barber</u>		<u>Laytonsville Md.</u>	

RECEIVED

MAY 20 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Dist of Col.</u>		COUNTY	
CITY (If outside corporate limits, write and give nearest town) <u>17 TOWN Takoma Park</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u>		<u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Washington San Hosp.</u>				STREET ADDRESS (If rural give location) <u>228 Webster St., N.E.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
		<u>Rosenfield</u>		DEATH: <u>May 4</u>		<u>1950</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE MARRIED. WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>May 4, 1955</u>	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
				Yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Milton Theodore Rosenfield</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Blanche Gager</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mothers Chart</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>776X Prematurity (gestation 21 weeks)</u>		DUE TO					
ANTECEDENT CAUSE (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-4</u> , 19 <u>55</u> , to <u>5-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-4</u> , 19 <u>55</u> , and that death occurred at <u>7:15</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M.D. 1433 Shafter St., N.W., Wash., D.C.</u>		DATE SIGNED <u>5-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Cremation</u>		DATE THEREOF <u>5-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Wash. San & Hosp.</u>		LOCATION (City, town, or county) (State) <u>Takoma Park 12 Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 6 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>R.A. Hare, M.D.</u>		ADDRESS <u>Wash. San & Hosp.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Written permission rec'd from both parents, [Signature] M.D.

2055263250

RECEIVED

MAY 9 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1953 Seminary Rd.</u>		STREET ADDRESS (If rural, give location) <u>1953 Seminary Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Emilia</u> <u>Scherger</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May</u> <u>25</u> <u>1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 17 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>90</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Teacher</u>		14. MOTHER'S MAIDEN NAME <u>Bernadine Lohman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>4</u>	
17. INFORMANT <u>Miss B. Scherger</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>422.2 Cerebral Embolism</u>	<u>1 day</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
<u>Ch. Ang. Myocarditis Curr. Probation</u>	<u>16 Mo</u>
<u>Gen. Atherosclerosis</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>5/24/55</u>	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/23/43, 1943, to 5/25/55, 1955, that I last saw the deceased alive on 5/24/55, 1955, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE <u>Dr. J. I. Morse</u>		ADDRESS <u>2030 Annelise Takomy Park Blvd</u>		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	LOCATION (City, town, or county) <u>Washington</u>	(State) <u>D.C.</u>	
DATE REC'D BY LOCAL REG. <u>May 27/55</u>	REGISTRAR'S SIGNATURE <u>Frances Potter</u>	24. FUNERAL DIRECTOR <u>Charles J. Talley</u>	ADDRESS <u>254 Carroll St. N.W.</u>		

BUREAU V. S.

MAY 31 1975

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04848

4855

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Silver Spring</u>		LENGTH OF STAY (in this place) <u>3 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2700 Harris Avenue</u>				STREET ADDRESS (If rural give location) <u>2700 Harris Ave.</u>			
3. NAME OF DECEASED: (First) <u>Marshall</u> (Middle) <u>Anderson</u> (Last) <u>Shaffer</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 25</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Nov. 24, 1899</u>	9. AGE last birthday: <u>55</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Architect</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>		11. BIRTHPLACE (State or foreign country): <u>Hamilton - Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Leigh Shaffer</u> Chief, Office of Technical Service, U.S. Public Health Dept.				14. MOTHER'S MAIDEN NAME: <u>Emily MacLean</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>1945-55</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Helen Shaffer - 2700 Harris</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac Arrest</u>							
ANTECEDENT CAUSE (S) <u>Hypertension</u>						<u>34 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None.</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 24, 1955</u> to <u>May 25, 1955</u> , that I last saw the deceased alive on <u>May 24, 1955</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph Stiel</u>		M. D. <u>927 Rushing Drive</u>		DATE SIGNED <u>5/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 27, 1955</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Warner C. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

BUREAU V. S.

MAY 31 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 223

4771

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY <u>47X-3</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Wash. Sanitarium</u>				STREET ADDRESS (If rural give location) <u>1413 Chittenden St N.W.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <u>Mollie</u> (Middle) <u>Shapiro</u> (Last)				OF DEATH: <u>May 31</u> 19 <u>55</u>			
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>?</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Rose</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>47710</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Wash. San + Hosp Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>331X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cerebro Vascular Accident</u>						<u>hrs.</u>	
DUE TO							
(B) <u>Arteriosclerotic Hypertension</u>						<u>years</u>	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-16</u> , 19 <u>53</u> to <u>5-30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-30</u> , 19 <u>55</u> , and that death occurred at <u>5:25</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Isidore Shulman</u>		ADDRESS <u>915-1944 NW</u>		DATE SIGNED <u>5-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Oxon Hill, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 31-1955</u>		REGISTRAR'S SIGNATURE <u>J. Wilton Dodd</u>		24. FUNERAL DIRECTOR <u>B. Hanyansky & Son</u>		ADDRESS <u>Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 1 1955

RECEIVED

4856 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04850
CERTIFICATE OF DEATH Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE --		COUNTY --	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>26 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>3541 Highwood Dr., S.E.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Effie</u> <u>Alma</u> <u>Simmonds</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>26</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>March 17, 1904</u>	9. AGE last birthday: <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Tavenner</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Franklin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-36-4785</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>170X</u> IMMEDIATE CAUSE (A) <u>portal vein</u> DUE TO ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Cancer of breast with metastases to liver, lungs, adrenals, retroperitoneal lymph nodes, and left carotid artery</u> DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>-- 2 --</u>		19B. MAJOR FINDINGS OF OPERATION: <u>--</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-- M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>May 20</u> , 1955, to <u>May 26</u> , 1955, that I last saw the deceased alive on <u>May 26</u> , 1955, and that death occurred at <u>6:45pM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Alexander Breslow</u>		ADDRESS <u>The Clinical Center</u> <u>M. D. Natl. Institutes of Health</u>		DATE SIGNED <u>5/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Cabman Manor Spd.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6/1/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Spittingly</u>		ADDRESS <u>131-11 St. S.E.</u> <u>Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04851

4857

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Bethesda</u>	<u>11 Days</u>	OR TOWN <u>Cherry Chase</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>74 Suburban</u>		STREET ADDRESS (If rural give location) <u>6900 Strathmore street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>William Alexander Smit</u>		OF DEATH: <u>May 11</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 24, 1892</u>
9. AGE last birthday <u>62</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months <u>9</u> Days <u>17</u>	Hours <u>17</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Real Estate</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country): <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>—</u>		14. MOTHER'S MAIDEN NAME: <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>6900 Strathmore st Mrs. Cleo Smit Cherry Chase, Md</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>420.1</u>			
IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Acute myocardial infarction</u>		<u>sev. hrs.</u>	
(B) <u>Thrombosis, left descending coronary artery</u>		<u>2 hrs.</u>	
(C) <u>Atherosclerosis, coronary</u>		<u>years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>old myocardial infarct.</u>		<u>?</u>	
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/11/55</u> to <u>5/11/55</u> , that I last saw the deceased alive on <u>5/11/55</u> , and that death occurred at <u>Cherry Chase, Md.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>George A. Gray, Jr.</u>		DATE SIGNED <u>5/12/55</u>	
M.D. <u>Cherry Chase, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>5-16-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Arlington National</u>		<u>Arlington Va</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/14/55</u>		REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Robert H. Humphrey</u>		<u>Bethesda, Md.</u>	

BUREAU V. S.

MAY 16 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery MARYLAND	CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda Rural	STATE Virginia COUNTY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fairfax
LENGTH OF STAY (in this place) 3 mo 13 days	HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital	STREET ADDRESS (If rural give location) 124 Fairview Drive	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
George Sanford SMITH		OF DEATH: May 22 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 1-28-15
9. AGE last birthday 40 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10B. KIND OF BUSINESS OR INDUSTRY: Gas Company	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: William C. SMITH		14. MOTHER'S MAIDEN NAME: Agnes MALONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217 10 2217	
17. INFORMANT'S ADDRESS: Wife Mrs. Eunice G. Smith Same as above			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(A) IMMEDIATE CAUSE Irreversible shock			5 days
(B) ANTECEDENT CAUSE (S) Multiple fat emboli			5 days
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 17 May 55		19B. MAJOR FINDINGS OF OPERATION: Non union, prox at femur	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY on duty, aircraft	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? at sea off North Carolina Coast			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Nov 15 1954		21E. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21F. HOW DID INJURY OCCUR? airplane crash			
22. I hereby certify that I attended the deceased from 22 May , 19 55 to 22 May , 19 55 that I last saw the deceased alive on 22 May , 19 55 , and that death occurred at 12:15A , from the causes and on the date stated above.			
SIGNATURE Robert G. KINDRED		ADDRESS U. S. Naval Hospital, NNMC, Bethesda, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 25 May 1955	
NAME OF CEMETERY OR CREMATORY Wicomico Memorial Cemetery		LOCATION (City, town, or county) (State) Wicomico Co, Maryland	
DATE REC'D BY LOCAL REGISTRAR 23 May 1955		REGISTRAR'S SIGNATURE Mary E. Parselley	
24. FUNERAL DIRECTOR'S ADDRESS R. A. Humphrey Funeral Home		7557 Wisconsin Avenue, Bethesda, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 26 1955

RECEIVED

4859

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u> <u>56</u>			
X TOWN <u>Bethesda Rural</u>		<u>1 day</u>		STREET ADDRESS (If rural give location) <u>12611 Bushey Drive</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				57			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Kendall Joseph SMITH</u>				<u>May 11 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>5-10-55</u>				<u>14 42</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME: <u>Floyd G. SMITH</u>				14. MOTHER'S MAIDEN NAME: <u>Ursula B. HAUSER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No 4</u>			16. SOCIAL SECURITY No. <u>- -</u>		17. INFORMANT & ADDRESS: <u>Father Mr. Floyd G. SMITH Same as above</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Prematurity</u>							<u>15 hrs</u>
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>10 May, 1955</u> , to <u>11 May, 19 55</u> that I last saw the deceased <u>alive on 11 May, 19 55</u> , and that death occurred at <u>4:45AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>D. J. PASCOE</u> LT				ADDRESS <u>MC USN U. S. Naval Hospital, NMMC, Bethesda, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>16 May 1955</u>		<u>Arlington National Cemetery</u>		<u>Arlington, Vir ginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12 May 1955</u>		<u>Mary E. Ganelly</u>		<u>R. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4860

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04854 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda (Rural)		LENGTH OF STAY DOA (Specify this place)		CITY (If outside corporate limits write RURAL and give nearest town) Bethesda, Maryland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital				STREET ADDRESS (If rural, give location) 7618 Clarendon Road			
3. NAME OF DECEASED: (First) Norman		(Middle) Truitt		(Last) SMITH		4. DATE OF DEATH (Month) May (Day) 26 (Year) 55	
5. SEX: Male	6. COLOR OR White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 3 Mar 97		9. AGE last birthday: 58 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Postal clerk		10b. KIND OF BUSINESS OR INDUSTRY: Retired		11. BIRTHPLACE (State or foreign country): Howard County, Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: ANTHONY SMITH				14. MOTHER'S MAIDEN NAME: VIRGINIA SHIPLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Wife Mrs. Miriam O. SMITH Same as above			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Coronary occlusion DUE TO Antecedent cause(s) (b) giving rise to the above cause DUE TO stating underlying cause last (c)						Sudden death	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: 2		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE James J. Burchart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> 5-26-55					
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 31 May 1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REG. 27 May 1955		REGISTRAR'S SIGNATURE Mary E. Canally		FUNERAL DIRECTOR R. A. Humphrey Funeral Home		ADDRESS 7557 Wisconsin Ave., Bethesda, Maryland	

BUREAU V. S.

MAY 31 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04855

4861

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Cherry Chase Md.</u>		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ch. Ch. Maryland</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4709 Re Russesphy.</u>				STREET ADDRESS (If rural give location) <u>4709 Re Russesphy.</u>			
3. NAME OF DECEASED: (Type or Print) <u>MATILEH (N) SORGENFREX</u>				4. DATE OF DEATH: (Month) <u>5</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>May 6, 1880</u> <u>75</u> yrs.	
9. AGE last birthday: <u>IF UNDER 1 YEAR</u>		10. AGE last birthday: <u>IF UNDER 24 HRS.</u>		11. BIRTHPLACE (State or foreign country): <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Henry Vierkamp</u>				14. MOTHER'S MAIDEN NAME: <u>Sophie CLAUSSEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>4 NO</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Linda Fletcher (Daughter)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
450.0 Immediate cause (a) <u>Pneumonia</u>						5 days	
Antecedent causes (s) (b) <u>Generalized arteriosclerosis</u>						5 years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>-0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 1950</u> , to <u>May 26, 1955</u> , that I last saw the deceased alive on <u>May 25, 1955</u> , and that death occurred at <u>5pm 5/26/55</u> from the causes and on the date stated above.							
SIGNATURE <u>Roger D. Sweetser M.D.</u>		(Degree or title)		ADDRESS <u>360 Sweetser Ave. N.W. Wash. D.C.</u>		DATE SIGNED <u>5-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-30-55</u>		<u>Mount Carmel</u>		<u>Mount Carmel Co. Iowa</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/28/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR		ADDRESS <u>Cherry Chase Funeral Home 5103 Wisc. ave. N.W. Wash. D.C.</u>	

BUREAU V. S.

MAY 31 1955

RECEIVED

4862

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	District of Columbia	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
Bethesda - Rural	11 Hrs. 26 Min.	Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
U.S. Naval Hospital	637 5th Street, N.E.		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) August	(Middle) Otto	(Last) STARKE	(Day) 5 (Year) 19 55
(Type or Print)			
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married	8. DATE OF BIRTH: 11-21-77
		9. AGE last birthday: 77 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
Civil Service US Govt		Retired	Washington, D.C.
13. FATHER'S NAME:		12. CITIZEN OF WHAT COUNTRY?	
Albert STARKE		U. S.	
14. MOTHER'S MAIDEN NAME:		17. INFORMANT & ADDRESS:	
Mary ADAMS		Wife Mrs. Lola Starke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.	
Yes		Spanish American Unknown	
18. MEDICAL CERTIFICATION		20. AUTOPSY?	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) acute pulmonary edema		1 day	
ANTECEDENT CAUSE (S) Hypertensive cardiovascular disease		unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		20. AUTOPSY?	
0		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5 May , 1955, to 5 May , 1955, that I last saw the deceased alive on 5 May , 1955, and that death occurred at 10:46 P M, from the causes and on the date stated above.			
SIGNATURE C. S. STROUD		ADDRESS MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
Burial		Lee Funeral Home	
DATE THEREOF 10 Mayr		LOCATION (City, town, or county) (State)	
Arlington National Cemetery		Arlington, V irginia	
DATE REC'D BY LOCAL REGISTRAR 6 May 1955		ADDRESS 4th and Mass Avenue, N.W. Washington, D.C.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information-carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4863

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04857
(04857)
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>4 Hours</u>		TOWN <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>suburban</u>				STREET ADDRESS (If rural, give location) <u>6625 Bradley Blvd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Peter Frederick Stebbings</u>				<u>May 31 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: (If UNDER 1 YEAR)	IF UNDER 24 HRS.		
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Feb. 28, 1944</u>	<u>11</u> yrs.	<u>3</u> Months	<u>3</u> Days	<u>11</u> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>school</u>		<u>school</u>		<u>Calif.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Stebbings</u>				<u>Joan Stevens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				<u>Mrs. Joan Stebbings</u> <u>6625-Bradley Blvd, Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
812X Immediate cause (a) <u>Abdominal hemorrhage due to rupture of liver</u>							
Antecedent cause(s) (b) <u>Sub-dural hemorrhage due to fracture of skull</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>fracture of both legs</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
<u>2</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>street</u>		21c. (City or town) (County) (State)			
		<u>Bethesda Monty Md</u>					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-31-55-3:45-P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>struck by truck (pedestrian)</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>James J. Brochant</u>		M. D.		<u>6-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial-Transit</u>		<u>55</u>		<u>Sleepy Hollow Cem.</u>		<u>Westchester Co. New York</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6/1/55</u>		<u>Bessie M. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

BUREAU V. 2

JUN 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04858

4772

CERTIFICATE OF DEATH

Reg. Dist. No. 229

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>		STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural, give location)	
TOWN <u>Lapont Park</u>		<u>10 days</u>		TOWN <u>Silver Spring</u>		<u>318 Northwest Blvd.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium Hosp.</u>				STREET ADDRESS <u>318 Northwest Blvd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Clarence Leon Stewart</u>				DATE OF DEATH: <u>5-6-1955</u>			
(Type or Print)							
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>9-27-98</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday <u>56</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Hawa</u>	
<u>Telegraph Operator</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Stewart</u>				14. MOTHER'S MAIDEN NAME: <u>Jessie Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Acute intra cerebellar hemorrhage</u>				<u>1 1/2 hrs</u>			
ANTECEDENT CAUSE (S) (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>5/5/55</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Internal hydrocephalus, Generalized atrophy</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4-25</u> , 19 <u>55</u> to <u>5-6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-5</u> , 19 <u>55</u> , and that death occurred at <u>5:40</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Garrett M. Swain</u>				ADDRESS <u>1904 R St. N.W.</u>			
DATE SIGNED <u>5/6/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial - Transit</u>		<u>May 10-1955</u>		<u>Memorial Park</u>		<u>Salina Kansas</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 6 1955</u>		REGISTRAR'S SIGNATURE <u>J. William Deeks</u>		24. FUNERAL DIRECTOR <u>Anna C. Young, Inc.</u>		ADDRESS <u>Salina, Kan.</u>	

RECEIVED

MAY 9 1955

BUREAU V. S.

4864

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Florida		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural		LENGTH OF STAY (in this place) 18 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Key West 48X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital				STREET ADDRESS (If rural give location) 618 White Street			
3. NAME OF DECEASED: (First) (Middle) (Last) Lawrence Michael SURRENCY				4. DATE (Month) (Day) (Year) OF DEATH: May 25 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: F 3-21-55	9. AGE last birthday yrs. 2		IF UNDER 1 YEAR Months 4 Days 4 Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None		10B. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Florida		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: John C. SURRENCY				14. MOTHER'S MAIDEN NAME: Gail SWEETING			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. - -		17. INFORMANT & ADDRESS: Father John C. SURRENCY CPL USMC Same as above			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Hydrocephalus, Congenital						2 mos.	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Peritonitis & Nephritis						14 days	
19A. DATE OF OPERATION: 5-11-55		19B. MAJOR FINDINGS OF OPERATION: Congenital hydrocephalus				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7 May , 19 55 , to 25 May , 19 55 , that I last saw the deceased alive on 25 May , 19 55 , and that death occurred at 8:55A M, from the causes and on the date stated above.							
SIGNATURE R. W. Mackie				ADDRESS		DATE SIGNED	
R. W. MACKIE LCDR MC USN U. S. Naval Hospital, NNMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 29 May 1955		NAME OF CEMETERY OR CREMATORY Private Cemetery		LOCATION (City, town, or county) (State) Key West Florida	
DATE REC'D BY LOCAL REGISTRAR 26 May 1955		REGISTRAR'S SIGNATURE Mary E. Carroll		FUNERAL DIRECTOR'S ADDRESS R. A. Humphrey Funeral Home 7557 Wisconsin Avenue, Bethesda, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

9V3599V99V

BUREAU V. S.

MAY 31 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

4779

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Montgomery</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Montgomery</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rockville</i>	<i>26</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>22 Bridge st.</i>		STREET ADDRESS (If rural give location) <i>22 Bridge street.</i>	<i>1</i>
3. NAME OF DECEASED: (First) <i>Erna</i> (Middle) <i>L.</i> (Last) <i>Swan</i>		DATE (Month) (Day) (Year) OF DEATH: <i>May 2 1955</i>	
5. SEX: <i>7</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Jan. 25, 1906</i>
9. AGE last birthday: <i>49</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Maryland</i>	11. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own Home</i>	
13. FATHER'S NAME: <i>James Reed</i>		14. MOTHER'S MAIDEN NAME: <i>Agnes Bean</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>yes</i>	
17. INFORMANT & ADDRESS: <i>Leo L. Swan - 7 Tem #2</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Extra-Abdominal</i>		<i>1 year</i>	
ANTECEDENT CAUSE (S) <i>Carcinomatous. 8th.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <i>Undetermined</i>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>Nov. 1954</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Metastatic nodes. Same undetermined</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Nov.</i> , 19 <i>54</i> , to <i>May 2</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Apr. 29, 1955</i> , and that death occurred at <i>11:15</i> A. M. from the causes and on the date stated above.			
SIGNATURE <i>Jack H. Harker M.D.</i>		DATE SIGNED <i>May 25</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-5-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5/3/55</i>		REGISTRAR'S SIGNATURE <i>Laurel H. Grogan</i>	
FUNERAL DIRECTOR <i>Robert H. Humphrey</i>		ADDRESS <i>Beth, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 4 1955

BUREAU V. S.

4773

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04861 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 223

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Montgomery	MARYLAND	STATE	Penna.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	17 TOWN Takoma Park	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN York 75x-3		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
75 Washington Sanitarium & Hospital			724 W. King St.,		
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	John	Ziegler	Sweitzer	5	22 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	Caucasian	Separated	7-5-71	83 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Salesman		Retired	Penna.		U.S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
William B. Sweitzer			Lemanda Ziegler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
4 No				Hospital Records.	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				
420.1 Immediate cause (a)..... Coronary occlusion				Sudden death
DUE TO				
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)		(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		
Frank J. Bruchart		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 5-22-55		
M. D.		ASSISTANT MEDICAL EXAM.		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)	
Burial	May 24, 1955	Boyers Cemetery	New Freedom, York Co., Pa.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS
May 23-1955	J. Arthur Noddy	J. Arthur Noddy, 254 Carroll St NW		2nd PK W.C.

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 24 1955
BUREAU V. S.

4865

CERTIFICATE OF DEATH

Reg. Dist. No. 215.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Virginia	COUNTY Arlington
CITY (If outside corporate limits, write RURAL or and give nearest town) Bethesda Rural	LENGTH OF STAY (in this place) 26 days	CITY (If outside corporate limits, write RURAL and give nearest town) Arlington 83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital		STREET ADDRESS (If rural give location) 3234 North Pershing Drive	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Edward	(Middle) Lee	(Last) TAYLOR II	(Month) May (Day) 29 (Year) 19 55
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 3-21-97
9. AGE last birthday 58 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Pilot		10B. KIND OF BUSINESS OR INDUSTRY: Commercial	
11. BIRTHPLACE (State or foreign country): Texas		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Edward L. TAYLOR		14. MOTHER'S MAIDEN NAME: Elizabeth SLOAN	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 057 01 7235	
17. INFORMANT & ADDRESS: Son Edward Lee TAYLOR III		Same as above	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Adeno carcinoma, rectum			30 months
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
21G. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
22. I hereby certify that I attended the deceased from 3 May , 19 55 , to 29 May , 19 55 , that I last saw the deceased alive on 29 May , 19 55 , and that death occurred at 9:25 P. , from the causes and on the date stated above.			
SIGNATURE E. J. RUPNIK		ADDRESS MMC, Bethesda, Maryland	
DATE SIGNED 30 May 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1 June 1955	
NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 30 May 1955		REGISTRAR'S SIGNATURE Mary E. Gassally	
ADDRESS Chambers Funeral Home		1400 Chapin Street, N.W., Washington, D.C.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4866

04863

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Bethesda</u>		<u>B.C.A.</u>		TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp.</u>				STREET ADDRESS (If rural, give location) <u>R.F.D. #2 (Scotland)</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Herman</u>		(Middle) <u>Thomas</u>		(Last) <u>Thomas</u>	
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH: <u>Apr. 19, 1929</u>	
9. AGE last birthday: <u>26</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>laborer</u>		11. BIRTHPLACE (State of foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry G. Thomas</u>				14. MOTHER'S MAIDEN NAME: <u>Emily Miles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Flora Thomas</u>		<u>2140 N Street Wash. D.C. n.w.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
982x Immediate cause (a) <u>Hemorrhage</u> Antecedent cause(s) (b) <u>Laceration of Rt femoral artery</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>stab wound at pelvic region</u>							few minutes
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <u>street</u>		21c. (City or town) <u>Rockville</u> (County) <u>montg</u> (State) <u>md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-22-55-2:15 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>stabbed during an argument</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lance J. Broschert</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>5-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>5/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Scotland</u>		LOCATION (City, town, or county) (State) <u>Rockville md</u>	
DATE REC'D BY LOCAL REG. <u>5/25/55</u>		REGISTRAR'S SIGNATURE <u>Lance J. Broschert</u>		24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville md</u>	

BUREAU V. S.

MAY 26 1955

RECEIVED

4774

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Takoma Park, Md</i>		<i>15 days</i>		TOWN <i>Hyattsville</i> <i>16-15-2</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Wash. San & Hospital</i>				STREET ADDRESS (If rural give location) <i>1513 Kennedy St.</i>			
3. NAME OF DECEASED: (First) <i>Jennie</i> (Middle) <i>Mae</i> (Last) <i>Thurman</i>				4. DATE (Month) <i>5</i> (Day) <i>24</i> (Year) <i>1955</i>			
5. SEX: <i>fe</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>2-7-1875</i>	
9. AGE last birthday <i>80</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Minnesota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>James Dilley</i>				14. MOTHER'S MAIDEN NAME: <i>Harriett Packey</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>4. No</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>Daughter & Wash. San & Hosp records</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE				(A) <i>Arteriosclerotic Heart Disease</i>			
ANTECEDENT CAUSE (S):				(B) <i>Generalized Arteriosclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8/12/49</i> , to <i>5/24, 1955</i> that I last saw the deceased alive on <i>5/24, 1955</i> , and that death occurred at <i>8:45 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Dean C. Harding</i>				ADDRESS <i>113 Carroll St. NW. Wash. DC</i> DATE SIGNED <i>5/24/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5/27/55</i>		NAME OF CEMETERY OR CREMATORY <i>Union Cemetery</i>		LOCATION (City, town, or county) (State) <i>Burtonsville, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 25-1955</i>		REGISTRAR'S SIGNATURE <i>J. Nelson Dodd</i>		24. FUNERAL DIRECTOR <i>Warner & Humphrey</i>		ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 26 1955

RECEIVED

04865

MARYLAND

4867

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>56</u> <u>Silver Spring</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>56</u> <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90</u> <u>Boswell Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>9110 Wire Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH JANE TIBBETS</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>1</u> (Year) <u>19 55</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Dec. 27, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>87</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Plymouth, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert S. Young</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth J. Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ellis W. Carnell, 9110 Wire Ave., S. S.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>several years</u> <u>Two weeks</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> (a) <u>Hypertensive cardiac disease</u> (b) <u>Broncho pneumonia</u> (c) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1955, to Apr 30, 1955, that I last saw the deceased alive on Apr 30, 1955, and that death occurred at 3:20 A.M. from the causes and on the date stated above.

SIGNATURE <u>Joan M. Andrews M.D.</u>		ADDRESS <u>No. 1 Colesville Rd. Silver Spring, Md.</u>		DATE SIGNED <u>5-1-55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>May 3, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	LOCATION (City, town, or county) <u>Washington, D. C.</u>	(State)
DATE REC'D BY LOCAL REG. <u>May 2/55</u>	REGISTRAR'S SIGNATURE <u>James Potter</u>	24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u> ADDRESS <u>Silver Spring, Md.</u>		

MARGIN RESERVED FOR BINDING

BUREAU V. 3

MAY 4 1955

RECEIVED

4775

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
17 TOWN <u>Takoma Park</u>	<u>6 1/2 hrs.</u>	TOWN <u>Hyattsville</u>	<u>16-15-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
75 <u>Washington San. Hospital</u>		<u>5404 20th Ave.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print)	(Middle) (Last)	(Month) (Day) (Year)	
<u>ALVADA</u>	<u>Woodrow</u>	<u>May</u>	<u>21</u>
<u>(Allie)</u>	<u>Toney</u>	<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>fe</u>	<u>Cauc.</u>	<u>Widowed</u>	<u>5-28-1875</u>
9. AGE last birthday		10. AGE last birthday	
<u>79</u> yrs.	<u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
		<u>6</u>	<u>30</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country):	
<u>Hwy--none</u>		<u>AMELIA Co. Virginia</u>	
10B. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY?	
<u>OWEN HOME</u>		<u>Amer.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Robert W. Plippin</u>		<u>Louisa Ellis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (no) or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>no</u>		<u>hospital chart</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Rupture of Interventricular Septum</u>			
ANTECEDENT CAUSE (S) (B) <u>Myocardial Infarction</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Occlusion</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Atelelectasis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
OF INJURY		While <input type="checkbox"/> Not while <input type="checkbox"/>	
M.		at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/20/1955</u> , to <u>5/21/1955</u> , that I last saw the deceased alive on <u>5/20/1955</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>500 E. Howard St. NW</u>	
		DATE SIGNED <u>5/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		NAME OF CEMETERY OR CREMATORY	
<u>Buried at Forest Lawn</u>		<u>Forest Lawn</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 21-55</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>	
REGISTER'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>8434 Silver Spring Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CRIMINAL ACTION ON DEATH

BUREAU V. S.

MAY 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04867

4868

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Virginia COUNTY Arlington	
CITY (If outside corporate limits, write RURAL OR TOWN) Silver Spring	LENGTH OF STAY (in this place) 2 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arlington	83x-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS Boswell Nursing Home		STREET ADDRESS (If rural give location) 3719 - 25th Rd., North	
3. NAME OF DECEASED: (First) PAREPA (Middle) G (Last) TRACEY		4. DATE (Month) (Day) (Year) OF DEATH May 27 1955	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Jan. 22, 1874
9. AGE last birthday: 81 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired		10B. KIND OF BUSINESS OR INDUSTRY: Housewife	
11. BIRTHPLACE (State or foreign country): Ripley, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Charles Galbreath		14. MOTHER'S MAIDEN NAME: Eliza Isabell Gaddis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: John C. Tracey, Arlington, Va.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 331X			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Cerebral Vascular accident		7 days	
(B) Generalized arteriosclerosis		years	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Mod. Hypertension			
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-5 , 19 54 to 5-27 , 19 55 that I last saw the deceased alive on 5-26 , 19 55 and that death occurred at 5:50 P.M. from the causes and on the date stated above.			
SIGNATURE [Signature]		DATE SIGNED 5-27-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Shipment & burial		NAME OF CEMETERY OR CREMATION LOCATION (City, town, or county) (State) Elmwood Cemetery Kansas City, Missouri	
DATE REC'D BY LOCAL REGISTRAR 5-31-55		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR [Signature]		ADDRESS Silver Spring, Md.	

BUREAU V. S.

JUN 3 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4869
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04868
 Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Silver Spring</u>		<u>5 yrs</u>		TOWN <u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>723 Boundary Ave.</u>				STREET ADDRESS (If rural, give location) <u>723 Boundary Ave.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>Ella</u>		<u>mae</u> <u>Villalon</u>		<u>May</u> <u>3</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. UNDER 1 YEAR IF UNDER 24 HRS.		
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>3/4/06</u>	<u>49</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home</u>		<u>Washington, D. C.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Harry W. Ensor</u>				<u>Edna Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
(If Yes, give war or date of service)		<u>69-052-0017</u>		<u>Mr. Pedro G. Villalon, 723 Boundary Ave. Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>Found dead on kitchen floor.</u>
Immediate cause		(a) <u>Hemorrhage due to laceration of</u>					
Antecedent cause(s)		(b) <u>fish wrists</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
<u>0</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5-3-55</u>					
<u>Frank J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/6/55</u>		<u>Ft. Lincoln Cemetery</u>		<u>Prince George County, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>5-4-55</u>		<u>James Potter</u>		<u>Warner E. Humphrey</u>		<u>8434 Ga. Ave. Silver Spring, Maryland</u>	

RECEIVED

4870

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda Rural</u>		1 day		OR TOWN <u>Alexandria</u> <u>83X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
51 <u>U. S. Naval Hospital</u>				<u>Presidential Gardens Apt A-3</u> ✓			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>9</u> <u>19 55</u>			
<u>Baby</u>		<u>Boy</u> <u>WALSH</u>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>5-9-55</u>			<u>8</u>	<u>36</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Michael J. WALSH</u>				14. MOTHER'S MAIDEN NAME: <u>Mildred A. CAMPBELL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT & ADDRESS: <u>Father Michael J. WALSH</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Prematurity at 27 weeks gestation</u>							<u>8 hrs 36 min.</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 May</u> , 1955, to <u>9 May</u> , 1955, that I last saw the deceased alive on <u>9 May</u> , 1955, and that death occurred at <u>8:20PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. S. Matthews, M.D.</u>				ADDRESS		DATE SIGNED	
W. S. MATTHEWS LCDR MC USN U. S. Naval Hospital, NMHC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Complete Cremation</u>		<u>14 May 1955</u>		<u>Prince George Co Crematory</u>		<u>Prince George Co Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>13 May 1955</u>		<u>Mary E. Parrelly</u>		<u>R. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4871

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04870

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Roanoke</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>118 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Roanoke</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>1211 Mormon Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lelia Dew Webb</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>May 8 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>November 10, 1897</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles A. Shaner</u>				14. MOTHER'S MAIDEN NAME: <u>Lelia P. Hyman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>2ndary to renal hypertension</u>							
(C) <u>Idiopathic Pulmonary Fibrosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19A. DATE OF OPERATION: <u>0 2 0</u>		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>none</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M. <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/>		21E. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. <u>10</u> , 1955., to <u>May 8</u> , 1955., that I last saw the deceased alive on <u>May 8</u> , 1955., and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William L. Morgan Jr.</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>5/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>5-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Roanoke</u>		LOCATION (City, town, or county) (State) <u>Roanoke, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/9/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

RECEIVED
MAY 11 1955
BUREAU V. 8

4872

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Fla.</u>		COUNTY <u>Orange</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		LENGTH OF STAY (in this place) <u>2 wks.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Winter Park</u> <u>48x-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharon Chronic Hospital</u>				STREET ADDRESS (If rural give location) <u>1949 Stanton Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Cora Jeannette Wellman</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 14 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Sept. 19, 1880</u> <u>74</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday <u>74</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Croftsville, New York, U.S.A.</u>	
13. FATHER'S NAME: <u>Ezra E. Snyder</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Peacock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Miss Thelma Wellman</u> <u>6604-1st St. N.W. Wash. D.C.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 hours			
420.1 IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>		DUE TO					
ANTECEDENT CAUSE (S) (B) <u>Hypertension, Arteriosclerosis</u>		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C) <u>CVA</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 29, 1955</u> , to <u>May 14, 1955</u> , that I last saw the deceased alive on <u>May 14</u> , 1955, and that death occurred at <u>11:40 P.M.</u> , from the causes and on the date stated above.							
live on <u>May 14</u> , 1955, and that death occurred at <u>11:40 P.M.</u>		M. from the causes and on the date stated above.		ADDRESS <u>M.D. 8401 University La., S.E. Md.</u>		DATE SIGNED <u>5/14/55</u>	
SIGNATURE <u>[Signature]</u>		M.D. <u>8401 University La., S.E. Md.</u>		DATE SIGNED <u>5/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hydenville, Pa. Co. Pa. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-17-55</u>		REGISTRAR'S SIGNATURE <u>Bertine B. Lawler</u>		24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>251 Carroll St. N.W. Takoma Park 12, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1955

BUREAU V. S.

4873

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>83X-3</u>			
X TOWN <u>Bethesda Rural</u>		<u>2 days</u>		STREET ADDRESS (If rural give location) <u>3412 North Vermont Street</u> ✓			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>May 11 19 55</u>			
<u>Jonathon Joseph WEST</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5-9-55</u>	9. AGE last birthday yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u>	IF UNDER 24 HRS. Days <u>2</u>	Hours <u>2</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Gordon H. WEST</u>				14. MOTHER'S MAIDEN NAME: <u>Lucille C. O'SULLIVAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY No. <u>- -</u>	17. INFORMANT & ADDRESS: <u>Father LTCOL Gordon H. WEST Same as above</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Sclerema</u>							<u>8 hrs.</u>
ANTECEDENT CAUSE (S) DUE TO <u>Prematurity</u>							<u>2 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>d</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>9 May</u> , 19 <u>55</u> to <u>11 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11 May</u> , 19 <u>55</u> , and that death occurred at <u>5:20 PM</u> from the causes and on the date stated above.							
SIGNATURF <u>Mary Allen</u>			ADDRESS <u>M. S. ALLEN LT MC USN U. S. Naval Hospital, NMHC, Bethesda, Maryland</u>				
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>16 May 1955</u>		<u>Arlington National Cemetery</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12 May 1955</u>		<u>Mary E. Carrelly</u>		<u>R. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04873

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>				TOWN <u>Bethesda</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6607 Elgin Lane</u>				STREET ADDRESS (If rural give location) <u>6607 Elgin Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Sarah Whirlow				May 11 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Widowed		Apr 9 1871	
9. AGE last birthday: If UNDER 1 YEAR		Months		Days		Hours	
84 yrs.		1		2			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife						Leeds, England	
12. CITIZEN OF WHAT COUNTRY?				United Sta.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Samuel Blow				? Farnsworth			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
4 No		None		O.F. Smith-6607 Elgin Lane, Beth. Md.			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X Immediate cause (a) <u>Cardiac Failure</u> approx 24 hrs							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u>							
(904.9) (c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					
30 March 1955		Fracture of neck of Left Femur					
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>14 Mar</u> , 19 <u>55</u> , to <u>11 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24 Apr</u> , 19 <u>55</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
Jack W Sanders		M.D.		Cabin John Md		11 May 1955	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 14-55		Parklawn Cem.		Rockville, Montg. Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5/12/55		Bessie M. Thompson		Robert A. Humphrey		Bethesda, Md.	

BUREAU V. S.

MAY 16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4875

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04874

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Gaithersburg Rural</u>		<u>5 Mo</u>		<u>Gaithersburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Rural. Md.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>William</u>		(Middle) <u>Eugene</u>		(Last) <u>Wilkerson</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Nov 30-1954</u>	
4. DATE OF DEATH: <u>May 18 1955</u>		9. AGE last birthday: <u>5</u> yrs. <u>5</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Infant</u>		11. BIRTHPLACE (State or foreign country): <u>Gaithersburg. Md</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME: <u>Hugh W. Wilkerson</u>				14. MOTHER'S MAIDEN NAME: <u>Nancy L. Selby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>g</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Hugh W. Wilkerson. Gaithersburg. Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
525X Immediate cause (a) <u>Aspiration gastric contents</u>						<u>1 hour</u>	
Antecedent causes (s) (b) <u>Interstitial Pneumonia</u>						<u>1 day</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12, 1955</u> , to <u>May 18, 1955</u> , that I last saw the deceased alive on <u>May 17, 1955</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Kernon S. Mortons</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Germantown Rd</u>		DATE SIGNED <u>May 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>5-20-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or County) (State) <u>Rockville. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 19-55</u>		REGISTRAR'S SIGNATURE <u>Abunda L. Gode</u>		24. FUNERAL DIRECTOR <u>Ernest C. Gartner, Gaithersburg. Md.</u>		ADDRESS	

20X4191405

BUREAU V. S.

MAY 24 1955

RECEIVED

4876

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>--</u>		COUNTY <u>--</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>74</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D. C.</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50</u> <u>The Clinical Center</u> <u>Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>255 - 12th St. S.E.</u>			
3. NAME OF DECEASED: (First) <u>Sarah</u>		(Middle) <u>Jane</u>		(Last) <u>Williams</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>3</u> <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>December 1, 1888</u>		9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Lieutenant Thompson</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of cervix with post-operative</u>							
ANTECEDENT CAUSE (S) DUE TO <u>bowel obstruction and peritonitis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive cardiovascular disease</u>							
19A. DATE OF OPERATION: <u>4-25-55</u> <u>5-3-55</u>		19B. MAJOR FINDINGS OF OPERATION <u>Stage IV carcinoma of cervix</u> <u>Small bowel obstruction</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 18, 1955</u> to <u>May 3, 1955</u> , that I last saw the deceased alive on <u>May 3, 1955</u> , and that death occurred at <u>3:00PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Josher M. Cramer</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>5-4-55</u>		M. D. <u>Natl. Institutes of Health</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Frazier Incl. Home</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/4/55</u>		REGISTRAR'S SIGNATURE <u>Debbie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Frazier Incl. Home</u>		ADDRESS <u>389-R-4 ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 6 1955
BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04876

4877

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Alabama</u>		COUNTY <u>40X-3</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>52</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mulga</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>58</u> <u>Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>Box 225</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Carol R. Wilson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>May</u> <u>20</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>18 November 1954</u>	9. AGE last birthday: <u>--</u> yrs. <u>6</u> Months <u>2</u> Days	IF UNDER 1 YEAR: <u>6</u> Months <u>2</u> Days		IF UNDER 24 HRS.: <u>--</u> Hours <u>--</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Lloyd Wilson</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Watkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Postoperative shock</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Congenital heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Pulmonary aortic window</u>							
(C) <u>Interatrial septal defect</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>May 19, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Interatrial septal defect; pulmonary aortic window</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>Mar. 29, 1955</u> , to <u>May 20, 1955</u> that I last saw the deceased alive on <u>May 20, 1955</u> , and that death occurred at <u>5:50a M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George C. Kenser M.D.</u>				ADDRESS <u>The Clinical Center</u>			
DATE SIGNED <u>5/20/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Interment</u>		DATE THEREOF <u>5-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Landusbury</u>		LOCATION (City, town, or county) (State) <u>Alabama</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/23/55</u>		REGISTRAR'S SIGNATURE <u>Beacie M. Thompson</u>		24. FUNERAL DIRECTOR <u>The S. H. News Co</u>		ADDRESS <u>2901-14th St NW</u>	

BUREAU V. S.

MAY 26 1955

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4878

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write and give nearest town) OR <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>2 yrs</u>	CITY (If outside corporate limits, write and give nearest town) OR <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harold Austin</u>		STREET ADDRESS (If rural give location) <u>8920 Galvin Court</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Harold</u>	(Middle) <u>Austin</u>	(Last) <u>Wood</u>	DATE OF DEATH <u>May 18 1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 10, 1885</u>
9. AGE last birthday <u>70</u> yrs.		10. UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>M. O.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Jefferson H. Wood</u>		14. MOTHER'S MAIDEN NAME: <u>Conthy P. Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.:	
17. INFORMANT & ADDRESS: <u>Carl H. Wood</u>		<u>8920 Galvin Court</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>E. Bowler</u>			
ANTECEDENT CAUSE (B) <u>Cerebral - long bleed</u>		<u>4 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Prostate Cancer primary</u>		<u>4 years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) (M.)		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1951</u> , to <u>5/18</u> , 1955 that I last saw the deceased alive on <u>5/18/55</u> , and that death occurred at <u>365 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Alfred H. W. M.D.</u>		DATE SIGNED <u>5/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/20/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5/19/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>H. Hines</u>		ADDRESS <u>2901 14th St. N.W. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4879 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04878			
Item 9, FilmG181 5-17-55 et CERTIFICATE OF DEATH			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
Bethesda - Rural	10 Mos. 2 days	Silver Spring	56
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	1
U. S. Naval Hospital		927 Northhampton Drive	
3. NAME OF DECEASED: (Type or Print)	(First) Bernard	(Middle) Basil	(Last) WRIGHT
4. DATE OF DEATH:	(Month) May	(Day) 4	(Year) 1955
5. SEX: Male	6. COLOR OR RACE: Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 12-8-19
9. AGE last birthday: 35 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner	11. BIRTHPLACE (State or foreign country): Indiana	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: William T. WRIGHT	14. MOTHER'S MAIDEN NAME: Mary NEWLAND	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes	16. SOCIAL SECURITY NO. 220 34 3721
17. INFORMANT & ADDRESS: Mrs. Dorothy Wright (wife)	18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 200.0			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Reticulum Cell Sarcoma		10 months	
DUE TO			
(B) with metastasis			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2 Aug , 1954, to 4 May , 1955, that I last saw the deceased alive on 4 May , 1955, and that death occurred at 12:55aM , from the causes and on the date stated above.			
SIGNATURE M. E. FLIPSE		ADDRESS	DATE SIGNED
M. E. FLIPSE LCDR, MC, USN		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 6-May 1955	NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Virginia	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Mary E. Flipse	24. FUNERAL DIRECTOR R. A. Pumphrey	ADDRESS Funeral Home 7557 Wisconsin Ave. Beth. Md.

BUREAU V. S.

MAY 9 1955

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4880

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 56 SILVER SPRING		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 417 HILLMOOR DRIVE				STREET ADDRESS (If rural give location) 417 HILLMOOR DRIVE			
3. NAME OF DECEASED: (First) CHARLES (Middle) J. (Last) ZELLER				4. DATE (Month) (Day) (Year) OF DEATH: MAY 15 1955			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Sept. 5, 1916	9. AGE last birthday: 38 yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: Dept. of Hwys. DC Gov't.		11. BIRTHPLACE (State or foreign country): Grand Junction, Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Charles A. Zeller				14. MOTHER'S MAIDEN NAME: Marie T. Franger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): yes		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service): WW II 561-03-9288		17. INFORMANT & ADDRESS: Mrs. Dorothy E. Zeller, 417 Hillmoor Drive Silver Spring, Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.0 Acute Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH approx 2-4 hrs.			
ANTECEDENT CAUSE (S): DUE TO				Anteroinfarctive Heart Disease 3-4 months			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: none 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July, 1954, to May 15, 1955, that I last saw the deceased alive on May 15, 1955, and that death occurred at 6:45 AM, from the causes and on the date stated above.							
SIGNATURE: Raech H. Potter		ADDRESS: M. D. 8641 - Colsonville Rd.		DATE SIGNED: May 15, 55		(State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: 5/18/55		NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery		LOCATION: Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR: 5-19-55		REGISTRAR'S SIGNATURE: James Potter		24. FUNERAL DIRECTOR: Warner L. Humphrey		ADDRESS: 8434 Georgia Ave. Silver Spring, Md.	

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MAY 23 1955

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